International policy co-ordination and HIV/AIDS: the impact of the WHO/GPA's global aids strategy on the development of national HIV/AIDS policies in Britain and Zambia

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Synopsis: The Impact of the WHO/GPA's Global AIDS Strategy on the Development of National Policies.

This thesis looks at the impact of the Global AIDS Strategy, an ambitious attempt to combat HIV/AIDS with a concerted, liberal campaign co-ordinated by the World Health Organisation (WHO).

The thesis adopts a policy analysis approach to examine the Strategy's effects on the development and implementation of national AIDS policies in two case countries, Britain and Zambia. Policy network theory is used as a meso-level, explanatory theory to examine the ways in which different groups were able to exert pressure to resist or apply the over-arching principles of the Strategy.

Policy development in both countries was affected both by the WHO as an operational organisation and the Global AIDS Strategy as an institution – "persistent and connected sets or rules ... that prescribe behavioural roles, constrain activity and shape expectations" (Keohane, 1990; 732). In the early years of the epidemic, WHO collected and disseminated evidence in a way that helped to develop an international consensus about the nature and significance of the HIV/AIDS problem. In Britain, the WHO's perceived authority was used to reinforce calls from the health policy community and from pressure groups for a liberal response to HIV/AIDS.

In Zambia's politically and economically unstable policy arena, however, WHO's interventions created a 'donor-dependent' network, a relatively large, interdependent network of weakly accountable state, non-government and donor agencies that acted effectively to exclude non-members. This effect of this network was to generate relatively bureaucratic and inappropriate responses to HIV/AIDS.

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Abbreviations used

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-based organisation
CSO	Civil society organisation
DG	Director-General
EAGA	Expert Advisory Group on AIDS
GCA	Global Commission on AIDS
GMC	WHO/GPA General Management Committee
GP	General Practitioner
GPA	Global Programme on AIDS
GRZ	Government of Zambia
HIV	Human Immuno-Deficiency virus
IAAG	Inter-Advisory Group on AIDS
IEC	Information and education campaign
ILO	International Labour Office
MMD	Movement for Multi-Party Democracy
MTP	Mid-Term Plan
NAPCP	National AIDS Prevention and Control Programme
NASTL	National AIDS, Sexually Transmitted Disease, Tuberculosis and Leprosy Programme
NGO	Non-government organisation
NORAD	Norwegian aid agency
STD	Sexually-transmitted disease
STP	Short-Term Plan
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens' Fund
UTH	University Teaching Hospital, Lusaka
WHA	World Health Assembly
WHO	World Health Organisation

Chapter one: The Global AIDS Strategy

Introduction

> *One of the glories of our era is that we have witnessed the birth of global solidarity — imperfect, struggling, yet nonetheless real — in the creation of the United Nations, in the concern about nuclear war, in the growing world-wide resolve to protect the environment, and in AIDS.*
>
> *WHO/GPA, 1989a: 7*

In 1985 the World Health Organisation (WHO), a specialised agency of the United Nations with responsibility for directing and co-ordinating international health work, began developing a trans-national strategy for dealing with the emerging problem of HIV/AIDS. The plan, which became known as the 'Global AIDS Strategy', was designed to "unite countries all over the world in a rational, co-ordinated and effective way to prevent the spread of AIDS and to reduce its impact on individuals and societies" (WHO, 1989b: 5). Its rationale was unambiguous: HIV/AIDS presented a serious threat to world health and organised international co-ordination was the only effective way to control the problem.

In 1987 the Strategy was unanimously endorsed by the UN General Assembly, the World Health Assembly and the Venice Summit of Heads of State. Over the next seven years it was to become the largest ever peace-time operation by a UN agency, galvanising an unparalleled flow of donor resources to developing countries. A sense of the political significance of this global strategy permeates all WHO's early literature on HIV/AIDS and gained particular resonance by 1989, when the collapse of the Berlin Wall offered the possibility of fully-integrated global co-operation unhindered by Cold War politics. The international response to HIV and AIDS was seen as evidence of a new era of international co-operation, in which scientists, government and non-government organisations could unite against a common threat. For the WHO AIDS programme's first director, the late Dr. Jonathan Mann, "AIDS science was more international than the science of any

other disease and perhaps any other scientific endeavour" (WHO, 1989a: 2).

The idea that the political primacy of the nation-state is being superceded by trans-national economic and political forces has become a key theme in sociological debate. For many, 'globalisation' is seen as a threat to national economies and cultures (Gelinas, 1999; Neufeld, 1999; Mishra, 1998). For others – including the architects of the Global AIDS Strategy – recent political, economic and technological developments offer the possibility of greater international co-operation in tackling key issues such as poverty, environmental regulation, world health and conflict management (Sachs, 1999; Short, 1998; WHO, 1989a).

This thesis examines the impact of an explicit and ambitious attempt to co-ordinate a global policy on the development of national AIDS policies in two case countries: Britain and Zambia. In so doing, it sheds light on the extent of, limits to and potential dangers of trans-national policy co-ordination. In its various guises as international expert, advocate and funding-agent, the WHO played a significant role in structuring national-level responses to HIV/AIDS. Yet though nominally a global strategy, it is scarcely surprising that very different relationships evolved between the WHO and national organisations in the developed and developing world. In Britain, one of the industrialised countries that were effectively underwriting the costs of implementing the Strategy, the WHO's not insignificant impact remained largely confined to advocacy and consensus-building. It supported national organisations that were lobbying for a liberal and concerted approach to HIV/AIDS. In Zambia, however, the WHO's more direct role as funding body led to the establishment of an ambitious programme of HIV/AIDS interventions which the WHO had neither the financial nor political resources to implement effectively. The result was an expensive, bureaucratic and inappropriate response to HIV/AIDS.

1. The Global AIDS Strategy

The basic premises of the global strategy were first outlined by staff at the WHO in

1985, but it was in 1987 that the strategy really began to come into effect. In February of that year, WHO inaugurated the Global Programme on AIDS (GPA) as an operational programme to implement the AIDS strategy. In May, the 40th World Health Assembly adopted resolution WHA40.26, calling for every country in the world to recognise the epidemic's threat and to develop their own national AIDS programme. This was followed by an apparently overwhelming international endorsement of the WHO's initiative. Within months, the UN General Assembly, the Venice Summit of Heads of States and a specially convened World Summit of Ministers of Health had ratified WHO's Strategy.

At the 41st World Health Assembly in 1989, this resolution was augmented by resolution WHA42.34, which recognised the special contribution that was being made by non-government organisations. Governments, inter-governmental organisations and non-government organisations (NGOs) had complementary roles and should be able to contribute to the world wide initiative in ways which were "commensurate with their respective qualities and potentials" WHO, 1989c: 1). It also included an undertaking by signatory states to avoid discrimination against people with HIV/AIDS (WHO, 1989). The Global AIDS Strategy was finally in place.

The figure below shows the key premises of the Global AIDS Strategy. On an organisational level, the WHO was to take the lead in co-ordinating an organised international response to HIV/AIDS. There can be some confusion over the terms co-operation, co-ordination and collaboration. Co-ordination and collaboration can be seen as alternative ways of achieving co-operation, parties acting together to achieve a mutually acceptable strategy. Collaboration requires parties not to defect from a mutually desirable strategy in favour of an individually preferable one. International regimes controlling fishing levels, for example, require states to forgo short-term income maximisation in favour of the longer-term, collective benefit of ecological (and ultimately commercial) sustainability. Co-ordination, however, requires parties "to pursue a common strategy in order to avoid the mutually undesirable outcome arising from the pursuit of divergent strategies"

(Little, 1997: 245). The Strategy explicitly sought trans-national co-ordination.

The Global AIDS Strategy then identified three objectives: to prevent HIV infection, to reduce the personal and social impact of HIV infection and to unify national and international efforts against AIDS. In the absence of an AIDS vaccine, the prevention element of the strategy was to be two-fold. Firstly, the spread of the disease was to be contained by information and education campaigns designed to modify individual behaviour. Secondly, a strategy of non-discrimination against people with HIV and AIDS was to be adopted. Discrimination, it was argued, would cause "unnecessary additional suffering" as well as threatening public health more generally (WHO/GPA, 1989a: 5). The stigmatisation of those with HIV/AIDS, they argued, would serve only to discourage people from seeking advice and information on reducing their risk of infection. It would also dissuade people who may have been exposed to the virus from coming forward for testing, thereby driving the problem 'underground'.

Figure 1: The Global AIDS Strategy

Signatories	WHO Member states
Commitments	Political, technical and financial resources
Cooperating partners	WHO/GPA Government (National AIDS Programmes) NGOs
Objectives	The prevention of HIV infection (information and education) Reduction of personal and social impact of AIDS (liberal, non-punitive approach) Unifying national and international efforts

The Global AIDS Strategy embodied a fusion of late 20th Century liberal ideals. Firstly, it represented Bretton Woods principles — in that it envisaged a UN organisation leading a co-ordinated international response to a world-wide problem. Its design also reflected an increasing emphasis on liberal pluralism and

the significance of non-government groups in a democratic, effective polity. Non-government groups (NGOs) became increasingly important development players throughout the 1970s and 1980s, the perception being that they could provide more effective services than corrupt and inefficient state agencies. By the late 1980s, this emphasis was strengthened by an emerging liberal consensus that the non-state sector played a vital role in generating wealth and ideas in parallel with the state, thereby acting as a check to inefficiency and authoritarianism (Robinson, 1996). Finally, and perhaps least obviously, the Strategy reflected an individualist, medico-liberal view of transmittable disease, predicated on individual rights and responsibilities. The state has a responsibility to educate people of the risks involved in particular activities and to protect the rights of those infected, but ultimate responsibility for the spread of the disease lay with individuals. An alternative, collectivist approach to controlling transmittable disease, is for the state to protect the general population by measures such as isolating infectious carriers, criminalising knowing transmission and/or refusing entry to — or deporting — infected aliens (Gordenker, Coate, Jonsson, and Soderholm, 1995). These types of population-based responses have been pursued in several states, including Cuba, China and Hungary (Berridge, 1996: 55; WHO, 1994b).

As the first international programme actively to address the problem of HIV/AIDS, the GPA had a critical role in formulating early AIDS policies. In the first place, it provided a central repository of information and ideas about the emerging epidemic. The global strategy was based on the WHO/GPA's appraisal of the nature of the problem and on its understanding of the best way to deal with it. In the second place, donor funding on AIDS was largely channelled through its programmes. The programme attracted significant support from donors with contributions rising from only US$0.11m in 1986 to US$58.77m the following year and US$129.63m in 1988 (Laws, 1996: 380). The GPA soon became the largest single division of the WHO and was unusual within the organisation in that it supplied not only technical guidance to over 160 countries, but also field staff and financial support (WHO/GPA, 1996: 3).

Gradually, however, the GPA's influence on international AIDS interventions declined. In part, this was the natural result of an increasing number of organisations implementing their own programmes. New organisations brought with them new perspectives and new funds. The World Bank and UN Development Programme (UNDP), for example, viewed the problem in terms of its economic impact, and designed programmes accordingly. At the same time, evolving knowledge of the disease brought with it a recognition that AIDS presented a more complex range of policy problems than had been envisaged. The GPA's original programme had been based on the vertically-structured health education programmes of the sort that had been successful in controlling epidemics such as typhoid and cholera. WHO-backed National AIDS Control Programmes (NACPs) were predicated on the importance of centralisation, of having a designated office with responsibility for national education campaigns. AIDS education, however, involved the culturally sensitive issue of sexuality. Many of the people most at risk were already socially and politically marginalised. Many were illiterate and/or had little access to the traditional channels of health education such as schools, health centres or community groups. Successful education programmes involved more diverse approaches and experiments were made with more community-based education, finding ways of communicating information in relevant and accessible ways. More significantly, it became increasingly apparent that many individual's ability to control the extent to which they were exposed to risk was constrained by their economic, political and social resources. Increasingly, HIV/AIDS began to be seen as a human rights issue, rather than as a technical and informational problem.

In the process, the homogeneity of AIDS policies began to fragment. In March 1990, its Director Jonathan Mann resigned citing important differences between his own and WHO Director General Hiroshi Nakajima's positions on various areas of policy (*Lancet*, 1990: 8691). Unusually for a senior international bureaucrat, Mann went public with his dissatisfaction, directly criticising Nakajima's lack of commitment to HIV/AIDS generally and to the GPA's emphasis on human rights, support for grass-roots organisations and the global availability for drugs.

Nakajima, he argued, had consistently tried to "inhibit and diminish GPA's activities" (*Lancet*, 1990: 8691). At the same time, WHO as an organisation was becoming concerned about funding shortages. In 1992 it adopted a new 'Paradigm for Health Action' to accelerate the achievement of health for all member states, which included the need to mobilise a wider pool of resources for health (WHO, 1992: 1).

The following year the World Health Assembly adopted the idea of replacing the GPA with a broader-based programme that would pool UN AIDS efforts. In January 1994 the WHO's executive board passed a resolution to establish a co-sponsored UN programme to "achieve global co-ordination of policies, approaches and funding in the urgent struggle to slow the spread of [AIDS]" (WHO, 1994a; 1). On December 31, 1995, the GPA was formally dis-established and replaced with UNAIDS. This organisation was to be administered by WHO in collaboration with the UNDP, the UN Children's Fund (UNICEF), the UN Population Fund (UNFPA), the UN Educational, Scientific and Cultural Organisation (UNESCO) and the World Bank. An official statement argued that "faced with a truly global emergency and its multi-sectoral needs, it is imperative that the UN response is comprehensive and effective. HIV/AIDS will not be controlled unless all of us, acting as a global community, unite our efforts, co-ordinate our actions and reduce duplication" (*Global AIDS News*, 1995: 1).

2. Research questions.

The Global AIDS Strategy is intriguing both for the ambitiousness of its remit and for the rapidity with which it established a formal international consensus on HIV/AIDS. HIV and AIDS provided policy-makers with a new problem, which impacted upon communities in diverse ways. Yet out of all the potential policy responses to it, a world-wide initiative was launched relatively early in the epidemic which had the specific aim of homogenising and co-ordinating national policies.

In many respects, the Global AIDS Strategy appeared to offer a prime opportunity

for international co-ordination. The collapse of the Berlin wall had brought to an end some of the most immediate political obstacles to trans-national, UN-driven policy co-ordination. The health sector is generally considered to be an area of 'low politics', in which non-state and non-economic groups have a potentially greater role in policy development than the 'high politics' of economics and national security (Walt, 1994: 42). Thus, attempts at trans-national policy co-ordination in the health initiatives have a greater chance of survival than those that present a more direct threat to national economic or strategic interests. HIV and AIDS presented problems which were genuinely international (Christakis, 1989). The HIV virus was relatively easy to transmit and, given the extent of international travel, one state's problem with HIV and AIDS could certainly affect others. Unlike most chronic diseases, its heaviest impact was on the young and economically active, which had grave implications for world labour markets. It was a new and poorly-understood problem, so that states could benefit from help and support from each other in combating it.

However, similar features are shared by a number of policy problems like environmental damage and global warming, and states have at no point reached anything like the same consensus about how to deal with them (Majone, 1989). How then, was such a consensus achieved? Some commentators argue that the particular characteristics of the HIV/AIDS issue made a strong, centralised response particularly appropriate (Christakis, 1989; Day and Kline, 1989). The majority of state policies are a response to relatively predictable events. Policy-makers have a set of precedents to inform their policy choices and an established language with which to explain them as they adapt to evolving circumstances. HIV and AIDS, however, seemed to come out of the blue. No one had predicted the epidemic, science had no solutions for it and no one was sure how the problem would evolve. Importantly, it also contained the potential for social disturbance, in a public backlash against people with, or suspected of having AIDS.

In a case study of the UK, Day and Klein (1989) argue that, given the complex nature of the emerging HIV/AIDS problem, the state's role in moulding and

informing public opinion was at least as important as its technical responses. Policy-making can be seen as a political process as much as an analytical one, a process of adjusting perceived reality to social values and *vice versa* (Gregory, 1993). In the absence of a technical solution, policy makers chose to adopt a programme of action based on the values of the medical profession and public health experts. Massive information campaigns deliberately promoted the message that AIDS was a widespread problem that could involve the whole population. In so doing, AIDS's potential for political disruption was minimised by rendering it an apolitical, 'clinical' problem, "so insulating the policy process from possible disruptive populist pressures" (Day and Klein, 1989:337). This, they argue, is a predictable response by policy-maker's to complex problems that threaten social cohesion.

On one level, the WHO/GPA's approach conforms to Day and Klein's model of AIDS policy-making in the UK. Its global strategy emphasised the potential threat to all, despite the fact that different continents had very different rates of infection. Yet it is not entirely clear why policy-maker's internationally should be so concerned about HIV/AIDS or why they chose to endorse the particular principles enshrined in the strategy. Examination of the evidence available to policy-makers at the time reveals it was not *necessarily* obvious that HIV/AIDS was a serious threat to world health, that it should be tackled within a liberal paradigm or that the WHO had the organisational capacity to spearhead such an ambitious global strategy. In other words, the three most basic tenets of the Global AIDS Strategy were contestable.

Firstly, in the mid-1980s, it need not have been obvious that AIDS was such an immediate and present danger that it required sweeping interventions worldwide. The reported incidence of AIDS was low at the time the Global AIDS Strategy was endorsed. As of May 1988, only 88,000 AIDS cases had been reported to the WHO — a drop in the ocean in terms of world health (WHO, 1988b). WHO argued that unreliable reporting and the long incubation period between infection with the HIV virus and the onset of AIDS meant that this figure was deceptive. It

estimated that 5 to 10 million were infected with HIV and that between 15 and 20 million would have become so by the year 2000 — all of whom would eventually go on to develop AIDS (WHO, 1989a). Yet even these estimates were low compared with other fatal diseases such as malaria, typhoid and even simple malnutrition (WHO, 1987). Not only was reported incidence low, but the disease had yet to be identified in large parts of the world. It was not thought that HIV or AIDS were present in Eastern and Central Asia, the Pacific region or Eastern Europe. In signing WHA40.26, state officials in these regions appeared to accept projections of the problem in the absence of *a priori* evidence of its significance as a national policy issue. Reliable evidence about HIV prevalence would only emerge when policy measures such as surveillance and testing were undertaken.

Secondly, it is intriguing that governments universally endorsed a Strategy that was liberal both in its size and underlying philosophy. In 1987, HIV and AIDS was still strongly associated with what were then referred to as 'risk groups' — sex-workers, homosexuals and intravenous drug-users (Watney, 1996). One potential response to this situation would be simply to clamp down on the behaviours then associated with HIV transmission — prostitution, drug-use and sex with multiple partners — or to introduce immigration restrictions (Gordenker *et al*, 1995; Berridge, 1996). In 1987, the US and the UK — two of the loudest voices in the UN system — were led by radical right-wing governments. Indeed, with the fall of the Berlin wall occurring as the Strategy was still being endorsed, the political climate more generally could be characterised as shifting to the right. Many governments were attempting to pare down the scale of state interventions in World Bank-backed structural adjustment programmes. Despite this, here were governments agreeing to commit substantial public resources towards a fundamentally liberal set of policies.

Finally, it was not clear that the WHO/GPA had the authority to command a global, homogenous initiative against HIV/AIDS. Constitutionally, it had no authority to coerce or even hold governments accountable for implementing the terms of the strategy. Even in terms of guidance and advice, the GPA was a

significant new departure for the WHO. Although WHO had a respected track record in combating diseases such as smallpox, its role had hitherto been confined to technical advice and support. Its greatest successes had been in identifying and controlling relatively small outbreaks of easily diagnosed and treatable diseases (Henderson, 1992). HIV and AIDS was untreatable, the HIV virus had only recently been identified and there was still controversy over its link to AIDS (Hodgkinson, 1996; Patton, 1990). Strictly speaking, this put the problem outside the WHO's legitimate area of technical competence.

The premises of the Global AIDS Strategy were, therefore, contestable and politically charged. The Strategy was endorsed *before* it had become immediately apparent that HIV/AIDS was a significant health or political risk in many of the signatory states. Rather than policy-makers coming to public health experts for a solution, policy-makers seem to have been persuaded that HIV/AIDS was, in fact, an issue they should be addressing in an organised, liberal way. The WHO itself would seem to have played a role in catalysing and organising the international consensus on HIV/AIDS.

Resolutions WHA40.26 and WHA42.34 were, however, just resolutions. They had no binding power and governments could not be held accountable for their effective implementation. To many writers, international resolutions are essentially empty gestures of international goodwill. In the final analysis, "delegates know they can ignore resolutions once they go home" (Walt, 1994: 142). This thesis seeks to establish whether the Strategy had any actual effect on the development of national policies and, if so, how that effect was achieved. The research was designed to try to answer three questions. Together, I hope to shed light on the ways that international organisations and agreements impact upon the development of national policies.

1. To what extent were the objectives of the WHO/GPA's Global AIDS Strategy achieved?
2. In what ways did the Strategy impact upon national AIDS policies?

3. What are the main factors that influenced the answers to question two?

The first question is designed to establish an effect. The Global AIDS Strategy was based on several core liberal principles. Were these principles actually embodied in national policies? The figure on page four is the first step towards identifying measurable 'outputs' of the strategy. I will establish whether governments committed resources to the problem and took steps towards creating a supportive legal environment, removed potentially discriminatory legislation and added non-discriminatory laws where necessary.

The second and third questions are designed to explore the causal links between the Global AIDS Strategy and any identified policy outputs. Governments may have made policy decisions that appear to comply with the resolution, but for quite different reasons. If the Strategy did influence the development of national policies, how was this effect achieved? If not, what were the main factors that curtailed its influence?

3. International relations and international agreements

AIDS emerged on to the international policy agenda as the Cold War ended, making it a useful place to re-examine theoretical approaches to understanding international co-ordination. Despite the wealth of literature on the subject, many researchers complain that traditional analytical frameworks for conceptualising contemporary international relations are poorly adjusted to understanding increasingly trans-national policy pressures (Anand, 1997; Mohan, 1997; Krause and Knight, 1995, Bennet, 1995; Chayes and Chayes, 1993).

The study of international co-ordination is a debate about state autonomy versus determinism and about the ways in which the international system is maintained and developed (Haas, 1992). It involves arguments about the extent to which national policies are determined or broadly conditioned by trans-national structural forces, or whether they are the product of highly contextual negotiations between groups.

Historically, perhaps the most dominant school of international relations has been that of realism, an enlightenment approach to understanding human interaction that sees politics as a series of rational decisions by key actors. The approach has a long tradition in political science and has been subject to revision and reinterpretation. However, different manifestations of realism share core emphases on the state, security and self help (Keohane, 1986). The international system is seen as one of competing states, international politics as a struggle for power (Carr, 1946, Morgenthau, 1951). Individual states are therefore conceived as autonomous actors, engaged in rigorous pursuit of its own interests.

To realists, then, international agreements represent something of a paradox. According to a realist logic, states will only comply with international agreements when it is in their interests so to do. Thus, the only way a state would comply with an international agreement that was not clearly in its interest is through the threat of military or economic sanction (Chayes and Chayes, 1993). This approach, however, can not explain the variety of circumstances in which states do reach agreement, peacefully and with little obvious benefit either financially or economically. The Global AIDS Strategy is a case in point, pioneered as it was by an organisation which had no coercive force and was dependent on the financial resources of its wealthier signatories.

Since the 1970s, there has been a resurgence of interest in international regimes — delineated areas of rule-governed activity — in the international system (Little, 1997). Revisionist neo-realist approaches to understanding regimes acknowledge that the international system is anarchic in structure, but concede that it has never been without systems of norms and rules. In different sectors at different times, states choose to co-operate with other states, even when it is not in their short-term interest, because to do so is in their longer-term strategic, diplomatic and/or economic interests. States establish regimes when unco-ordinated strategies can interact to produce sub-optimal outcomes. However, the norms and values upon which regimes are based are influenced disproportionately by the most powerful state or states within the international political system. Thus, regimes generate

differential benefits for states. Power is a central feature of regime creation and survival, with powerful states effectively able to instigate or, if necessary, veto emerging regimes (Little, 1997). The challenge to researchers then becomes an empirical one, identifying the way in which a particular state weighs its short-term national costs against the practical and diplomatic advantages conferred by international co-operation in a particular sector (Little, 1997; Caporaso, 1992). Thus, analysts apply game theory to explain why states may chose to adhere to the principles and norms underlying a regime to which they are opposed. For realists, the key impediment to regime formation is the problem of how to co-ordinate effectively in conditions of imperfect information and communication.

A second major approach to understanding regimes, liberal-institutionalism, shares many of the core assumptions of neo-realism, but has a more benign view of their potential for promoting the common good (Keohane, 1986). Like neo-realists, liberal-institutionalists use game theory to analyse how states develop policy preferences, but focus on the way that regimes allow states to overcome obstacles to collaboration in an anarchic state system (Little, 1997). In this approach, a regime is likely to become more sustainable, and individual states less likely to flout its terms, when it is supported by a benign hegemon or when member states fear that individualistic actions will adversely affect international relations in the future.

Such approaches, however, have weaknesses. In the first place, they tend to over-simplify the question of 'national interest'. Studies of national level policies show that the state may have conflicting goals, or be unclear about the particular outcomes of different policy goals (Berridge, 1996; Majone, 1989; Skocpol, 1985). Thus, the idea that a single decision-making body rationally weighs up its choices is unrealistic. Even if a state could clearly define its national interests, it is unlikely to be able to execute them unilaterally. Detailed studies of policy developments at the national level show 'government' to be a site of conflict between different interest groups, with policy-decisions made incrementally in a process of trade-offs and compromises (Hulme and Murphree, 1999; Lewis, 1998; Clayton, 1998).

Pluralists argue that realism over-emphasises the autonomy of state actors, ignoring the various influences of trans-national actors such as multi-national companies, NGOs and international organisations (Willetts, 1993; Keck and Sikkink, 1998). Since neo-realists concede that a state may make expedient compromises to forestall political antagonism from other groups, the extent of their autonomy is open to question (Chayes and Chayes, 1993). In trying to undermine the realist idea that states are autonomous actors, early pluralist accounts of political processes tended towards over-compensation. Having established that political outcomes are dependent on negotiation between different groups, they failed to account for differences *between* groups in their ability to effect change (Skocpol, 1985). Certain groups are more organised than others and have greater financial and economic resources with which to influence policy. Some theorists have adopted a historical approach to argue that, in certain circumstances, states have limited autonomy to use their resources to enforce change from above or to change the circumstances in which other groups operate, thereby undermining them (Stepan, 1985; Amsden, 1985). These studies adopt an essentially *relational* approach to understanding national political developments, arguing that policy outcomes need to be understood within the context of the interests and capacities of other groups (Skocpol, 1985).

If, however, international agreements pose something of a paradox for realist approaches to understanding international relations, they also pose a problem for pluralist approaches. International agreements take place at state level. They represent an undertaking by states to adopt particular policies during and beyond the life-time of a particular government. According to a pluralist logic, however, state governments are unlikely to have a sufficient degree of autonomy to make such undertakings meaningful. Policy decisions are the product of the interplay of domestic forces and that process cannot be short-circuited. Thus, international resolutions may have little value other than general statements of goodwill or intent. Once again, empirical analysis of particular situations is called for.

A third, functionalist approach, takes a more optimistic approach to international

agreements, arguing that the increasing economic interdependency of nations necessarily leads to a convergence of policy decisions (Haas, 1964). In direct opposition to realist approaches, Henkin (1989) and Chayes and Chayes (1993) contend that most states comply with international agreements most of the time. To do so, they argue, is efficient in that it minimises the duplication of research and policy development and reflects the way in which organisations react to policy issues in an innately conservative way. Problems can be settled within international frameworks of norms and 'best practice'. Increasingly, theorists are explaining international policy convergence in term of the spread of ideas and values. At its boldest, exponents argue that the end of the 20th Century has seen the final victory of economic and political liberalism, the "triumph of the West, of the Western *idea*" (Fukuyama, 1989: 4). While economic upheavals and the resurgence of nationalism over the last decade have eroded the confidence of this form of determinism, there remains an argument that national policy developments are consciously and unconsciously affected by the values and ideas disseminated at international policy fora. In a seminal essay first published in 1966, Inis Claude argued that one of the UN's primary functions was 'collective legitimation'. Politics, he argued, is not simply a struggle for power but a contest for legitimacy, by which means power is converted into authority and possession validated as ownership. Post World War II, the function of legitimation is increasingly being conferred upon multi-lateral organisations. State powers need multi-lateral endorsement of their position. Though proclamations of UN approval or disapproval had no legal significance, statesmen had *made* them important by attaching importance to them. The UN movement could provide politically significant approval and disapproval of the claims, policies and actions of states (Claude, 1966).

A special edition of *International Organisation* in 1992 adopted a similar line of argument by developing the notion of 'epistemic communities', a "network of professionals with recognised expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area" (Haas, 1992: 3). These communities can, the authors argue, play a key role

in international policy co-ordination by putting forward a plausible framework for understanding complex problems. By organising knowledge in particular forms they can influence the way states formulate policy (Haas, 1992).

This notion of epistemic communities is useful for understanding policy responses to HIV/AIDS. When the disease began to emerge, the relatively small number of medical experts and individuals directly affected by the disease committed significant resources towards making contacts with each other and pooling information about the issue (Berridge, 1996). This 'community' was not entirely homogenous. Like most groups, its identity was perhaps more coherent viewed from the outside, by people who were sceptical that AIDS was a serious problem. Different groups had different priorities and international AIDS conferences were sometimes acrimonious (Berridge, 1996). There was, however, especially in the early years of HIV/AIDS, a definite sense of shared purpose. HIV/AIDS must be brought onto the national and international political agenda. From the mid-Eighties, the WHO's Global Programme on AIDS became an increasingly important part of this 'epistemic' community. They organised international conferences that attracted a wide range of people. Their staff represented members of the community from around the world. Executive staff had all developed some expertise in the area and all shared the programme's basic, liberal values in relation to HIV/AIDS.

However, to acknowledge that an epistemic community exists, is not to explain its impact on policy outcomes. The notion of epistemic communities adds an important insight into trans-national policy influences, but still raises the problem of the relative influence of different groups in the policy process. Implicit throughout the literature on epistemic communities, is the notion that their influence is greatest at times of uncertainty. State actors' temporary indecision within a knowledge area can provide an opportunity for other groups to affect the way problems are perceived. That influence, however, is likely to be temporary and is certainly constrained both by the domestic political environment and the distribution of power internationally (Hall and Ikenberry, 1989).

Another critique of functionalism can be generated from the policy analysis literature, rather than international relations theory. In *Evidence, Argument and Persusion*, Majone (1989) argues that policies are not simply the result of rational evaluation of objective criterion. 'Scientific' evidence in a policy area is often ambiguous and contestable. Different groups may frame problems very differently, prioritising different aspects of a problem and asserting different causal relationships. It follows that the choice of which group or groups of experts to believe has huge impacts upon subsequent policy development and is inherently political. Policy makers rarely have reliable and objective systems for gauging the quality of scientific explanations of particular problems. Instead, the relative weight accorded to different conceptions is dependent on a variety of factors. Some groups are viewed as more authoritative and unbiased than others, but this is at least in part a value judgement based on preference, history or ideological predisposition. Expert groups having to play by the 'rules of the game' if they are to be taken seriously. Historical and ideological factors affect which groups are recognised as expert, competent and authoritative.

The weakness of the functionalist approach is that it tends towards determinism (Skocpol, 1985). By de-politicising the concept of 'recognised expertise' and assuming that international policy convergence is inevitable, functionalist approaches risk underplaying the significance of cultural, socio-economic, administrative and political factors in determining the outcome of attempts at international co-ordination (Kenny, 1999; Knill, 1998; Mohan, 1997; Krause and Knight, 1995; Cliff, 1993). A related criticism is that it tends to underplay the structural differences between states in terms of power (Strange, 1988). Relatively little systematic research has been done on the extent to which socio-economic differences between states affect the rate and manner of policy convergence. Functionalist theory has been largely derived from regional convergence in industrialised countries, particularly Europe. Developing countries are mentioned in asides, but there is little agreement as to whether relative poverty actually increases the likelihood of states conforming to international standards. For some

writers, low-income countries must necessarily find it harder to implement international standards (Chayes and Chayes, 1993). There is another school of thought, however that argues precisely the opposite. Wealthy countries, particularly the USA, enjoy considerable autonomy from and control over the trend of international agreements while lower-income countries are frequently obliged to comply with international agreements because they can neither afford to develop their own policy strategies nor antagonise other states (Strange, 1988).

4. The policy analysis approach

I have argued that the international relations literature is relatively weak at explaining international agreements and that the subject raises several analytical problems. First, there is the question of the relative influence of different groups — national and international — in the *actual* development of policies (as opposed to the mere declaration of intent). Secondly there is a question about the different *forms* of influence. In certain conditions, international epistemic communities may be able to influence the way policy-makers perceive and respond to policy problems. How is that influence achieved and what are the major opportunities and constraints of that influence? Finally, it is unclear how differences in economic development affect the extent to which countries comply with international agreements and their relationships with international organisations generally.

In a study of the impact of forty years of international initiatives on population control through family planning, Lee and Walt (1995: 257) argue that the influence of "well-intended declarations and financial pledges" can only be understood by adopting a policy analysis approach. Only by carefully examining policy evolution in a particular context over a particular period can you begin to gauge how far international agreements actually impact upon the national policy process. The authors argue that in four pairs of (low-income) case countries, national family planning policies and programmes have been shaped to varying degrees by international organisations' attempts at promoting family planning as a significant health and population issue. The extent of this influence, they argue, was ultimately dependent on the 'compatibility' between national and global policy

contexts. Firstly, it is argued that the degree of support by governments for family planning corresponds with that of the country's relations with Western countries over time. The better the relations, the more receptive national elites were to the global population agenda. Secondly, it is held that support for family planning is influenced by the changing economic circumstances of each country. When economic problems have been perceived as urgent by policy elites, family planning moved up the agenda. In post-independence Zambia, for example, nationalist leader Kenneth Kaunda was "likely" to have been resistant to Western-led family planning agenda on the grounds of its being seen as part of a colonial past. The politics of non-alignment were made possible by the country's relative economic prosperity through its copper exports. Years later, structural shifts in the global political economy *inter alia* weakened the bargaining power of developing countries and increased their reliance on donor aid. This in turn led to a "policy context which was more conducive to [family planning]" (Lee and Walt, 1995: 264).

Though a timely illustration of the political tensions inherent in international policy interventions, Lee and Walt's study still raises some serious questions. If countries remain relatively immune from international interventions so long as they remain solvent, do individual international organisations *per se* have any effective influence over policy development or was the apparent adoption of international values only a fleeting symptom of economic crisis? In the study, case countries' compliance with the family planning agenda is measured only by its state officials' pronouncements at international conferences. It is therefore difficult to judge whether these statements represent a politically expedient but insincere concession to economic necessity, or a harmonious new phase of international partnership.

The study is also weakened by an unacknowledged ambivalence about the policy effects of donor-dependence. On page 264, donor dependency is seen as creating a decline in the relative autonomy of states by reducing their bargaining power forcing them to adopt an international policy agenda they would reject when they enjoyed financial independence. By page 265, high levels of donor aid are seen as

a symptom of "warming relations" between low-income countries and Western countries. In this, friendly policy environment, elites become more receptive to family planning arguments. The authors' two pre-conditions of compliance – economic crisis and 'good relations' with Western countries – could in fact be alternative explanations for elites apparent endorsement of population control as a central policy objective. Dolowitz and Marsh (1996: 40) have developed a more nuanced analysis of the process by which ideas, policies and programmes are fed into the policy-making arena in another time or place. The authors regard 'coercive' and 'voluntary' policy transfer as opposite ends of a spectrum. For the majority of bureaucrats in developing countries, policies are adopted after a mixture of coercion and 'lesson drawing' from the policies of other states. Economic or political crisis challenges existing policies and forces bureaucrats to review and adopt policies from abroad.

Whatever the motivation for espousing the language of international norms, it remains unclear how apparent shifts in elite discourse actually impact upon subsequent policy developments. A recent study has shown that elite attitudes are a relatively poor indicator of subsequent policy development and performance (Kenny, 1999). Elites in low-income countries do not necessarily have the capacity to implement policy reforms (Grindle and Thomas, 1991). Serious local resistance can stop policy reforms even when they are supported by members of policy elites and have been made a condition of further aid (Killick, 1997). Once again, it becomes clear that it is impossible to understand the nature and extent of external influences on policy without understanding the specific context in which policies are negotiated and to trace through the policy development beyond declarations at international conferences.

Summary and conclusion

In this chapter, I have discussed the Global AIDS Strategy and argued that it offers a useful place to look at the influence of international organisations post Cold War.

Conventional international relations macro-theories are ill-equipped to conceptualise the influence of international resolutions and international organisations on the development of national policies. Realist approaches over-estimate the extent to which state actors have clearly defined goals and agreed strategies to achieve them. In practice, the state is a site of conflict, allowing room for both non-state and trans-national organisations to influence the way problems are perceived and tackled. Pluralist accounts of policy-making, however, tend to over-estimate the extent to which national policy decisions are the result of interplay between interested organisations while underestimating the extent to which differences in power affect different organisations' bargaining power. They have also tended to focus on the national level, at the expense of investigating international pressures on policy. Functionalist approaches tend towards determinism and underplay the extent to which groups are able to frustrate attempts at international policy co-ordination. They also reveal a degree of confusion about how low-income countries fit into the functionalist framework. Does low income make countries more or less likely to comply with international agreements?

Policy analysis approaches have greater potential to analyse how different groups may be able to influence policy development at national and international level. Lee and Walt's (1995) study of the effects of international agreements on population control shows how their impact is dependent on the policy environment at national level, and that the relationship between national and international actors varies over time. Though undoubtedly a step forward in understanding the impact of international agreements, their analysis leaves two key issues unresolved. The first issue is the extent to which impact can be gauged by what officials say at international conferences. Governments that are dependent on aid are clearly motivated to appear to toe the international line. Whether these pronouncements have any impact upon policy is a different matter. Governments may not have the capacity or even desire to implement them. We cannot gauge the actual impact of international agreements without a more thorough analysis of policy development over time. The second issue raised is the ambiguity around international 'pushes'

and 'pulls'. Does increasing economic hardship and dependence on aid force national decision-makers to adopt international policy agendas, or is it more a case that the donor/donee relationship helps to generate a greater understanding of and sympathy with said agendas? These questions cannot be answered without a more detailed understanding of *how* policy development in low-income states is influenced by international organisations. To what extent do 'epistemic' values at the international level influence the way problems are perceived and how far are the effects of this influence mitigated by the interests and capacities of groups at national level?

In this study I will use a detailed empirical investigation of two case sites to explore the ways in which the WHO/GPA's Global AIDS Strategy influenced the development of national policies. Traditional approaches to international agreements have often focused on narrow analyses of government-to-government relationships between states. In so doing they have tended to underplay the role of non-state actors in forming state government attitudes to multi-lateralism as well as the impact of multi-lateral diplomacy on state policies. By adopting an explicitly relational perspective it follows that this study requires a rather broader unit of analysis than simply the WHO/GPA as an operational organisation. I will therefore look also at the Global AIDS Strategy as a multilateral institution, where institution is defined as "persistent and connected sets or rules, formal and informal, that prescribe behavioural roles, constrain activity and shape expectations" (Keohane, 1990; 732). The WHO/GPA is an important and integral part of this multilateral institution, but it is not the whole part.

This thesis examines the extent to which international 'epistemic' values influenced the development of AIDS policies in one high- and one low-income state. It will look at how the WHO sought to influence national policy actors and the main factors that limited or increased its influence. In the following chapter, I will outline a conceptual framework for understanding the impact of international agreements in the development of national policies. The approach assumes that different groups can impact on the way policies are developed and implemented,

but that their relative influence is path dependent and varies according to the particular context in which they operate. In the third chapter, I will discuss the methodological issues raised by these research goals and the methods used in this study. The fourth chapter analyses the policy environment in the two case countries at the time the strategy was being implemented. In the fifth and sixth chapters, I will discuss the ways in which the WHO/GPA and the Global AIDS Strategy impacted upon the development of national policies. The final chapter will discuss the theoretical implications of these findings for understanding trans-national policy co-ordination.

Chapter two: Policy and power

Introduction

In the previous chapter I defined three research questions and argued that the main approaches to International Relations provide a relatively poor framework for analysing the influence of international agreements. In this chapter, I will develop a framework for understanding the Global AIDS Strategy's impact on policy development. The discussion of the previous chapter raised three key issues that need to be addressed if we are to understand the Global AIDS Strategy's impact. The first issue raised is the empirical question of how far pronouncements at the international level actually go on to influence policy development. In the first section of this chapter I will set out the key tools of the policy analysis literature that will be used to examine HIV/AIDS policy development in Britain. Policy analysis will provide a framework for empirical analysis of the different stages in the policy process and how different groups may have opportunities to influence policy development at each stage.

The second issue raised is more abstract, and concerns the *relative* influence of different groups. Though various groups may influence policy in particular circumstances, not all groups have equal ability to effect change. The policy environment is not a neutral arena for negotiation (Ham, 1999: Chapter seven). For a number of reasons, some group interests can be represented more consistently than others. The level of influence on policy of different groups is to some extent path dependent, with some groups having institutionalised advantages over others. These other groups may have a limited ability to influence policy, but not in the conditions they would choose (Ham, 1999: Chapter seven). In the second section, policy network theory is used as a means of explaining how some groups are able to act together to increase their relative influence over policy development, effectively excluding other groups from key stages of the policy process. This section will discuss the question of power in the international system. Policy network theory has been used at a number of different theoretical

levels, but in this thesis it is used as a meso-level theory to explain structural differences between groups in terms of the ability to influence policy.

The third issue raised is the question of drawing international comparisons between rich and poor countries. International relations literature is, in the main, based on studies of industrialised countries. The literature remains divided about how low-income countries 'fit' into theoretical frameworks that have been developed to explain political phenomena in the North. In the third section of this chapter, I will set out a framework for identifying the key groups involved in the development of health policies at a national level. The discussions of the previous two sections will demonstrate that the relative influence of these groups in particular circumstances will be path dependent. The organisations involved are, however, similar enough to make international comparisons of the relative influence of one of the groups — the WHO/GPA — on policy development.

1. Understanding the policy process

Following Lee and Walt (1995), this study adopts a policy analysis framework to understand the influence of international agreements on national policy. Policy analysis comprises a complex blend of insights from organisational analysis, sociology, and political theory. In colloquial usage, the term 'policy' is most often viewed as a (written) set of objectives; a statement of an overall organisation's direction. In policy analysis, this type of written document is just one, concrete manifestation of a complex set of decisions, political interactions and expected — and unexpected — consequences. Policy is not just what it says, but what it does. In this section, I will discuss three key approaches to analysing policy, state-centred approaches, society-centred approaches and the 'garbage can' model.

A. State-centred approaches

Perhaps the most enduring accounts of the process by which policies are designed and implemented assume that policies are (or can be) the result of informed decisions by rational actors. Within this state-centred or 'top down' approach, the role of policy analysis is to understand and thereby improve the way that policy-

makers design and manage policy innovations. State-centred or top-down approaches take different forms. At one, rationalist extreme it provides an innately prescriptive model for bureaucratic policy-making. Centralised economic planning in developing countries during the 1970s, for example, was driven by the assumption that centralised policy-making by skilled technocrats was an achievable and desirable means to economic and social 'development'.

Increasingly, authors such as Wihtol (1988), whose work is discussed in greater detail below, use elements of the 'top-down' policy literature in a rather different way. Policy analysis is used as a means of analysing the different stages of policy, showing how central policy directives can be frustrated by organisational and political stresses at the periphery. However, despite these differences in tone, Sabatier (1986) argues that top-down approaches share essential features. They each take a policy decision by governmental officials as their starting point and then ask a series of questions. To what extent were the objectives achieved; what factors affected this; to what extent were the actions of implementing officials consistent with the objectives and procedures outlined in that policy decision and how was the policy reformulated over time? State-centred approaches accept that other actors can radically affect the way in which policies are implemented, but use policy analysis as a means of minimising the potential threat of these 'external' factors. As such, they contain a prescriptive element, in that they assume that it should be both possible and desirable for well-informed state policy-makers to design and implement 'rational', effective policies.

For some, like Lindblom (1979), policy-makers can actually take advantage of the unpredictability of policy implementation. Policy-making is not a clinical science. Unforeseen factors cause policies to impact in unforeseen ways. Shrewd policy makers may, however, develop ways of adapting policies to these influences. In so doing they can make the policy-process more responsive to local conditions and ultimately more effective: the 'science of muddling through'. This approach is echoed in the work of Rondinelli (1993), who argues that in the complex and uncertain policy environment of developing countries, projects should best be viewed as experiments, reducing uncertainties incrementally. Viewed cumulatively,

projects could gradually develop planning and administrative capacities. In a rather different approach, Grindle and Thomas (1991) argue that policy-makers should make more active attempts to understand the politics of implementation. In so doing, skilled policy-makers will be better able to predict and avoid political obstacles to implementation. In this formulation, the 'politics' of policy-making are seen as an integral part of successful policy management, rather than as an impediment to it.

i. The policy cycle

The advantage of the state-centred approach to policy analysis is its conceptual clarity. Policy analysts offer a way of schematising the complex evolution of policy decisions into identifiable stages, the model of the policy cycle. Though different analysts configure the phases of the cycle slightly differently, they contain the same basic elements. Policies go through common, identifiable stages of formulation, organisation, evaluation and finally termination, or more often reformulation as the 'policy cycle' begins again. The limitation of Lee and Walt's (1995) study of the effect of international agreements is that it uses policy analysis to explore only the very earliest, agenda-setting stage of the policy cycle. The study 'stops' at the stage at which officials make a formal pronouncement on population control. The policy process model highlights how different groups can impact upon the way initial policy goals are operationalised and implemented.

- *Agenda-setting*

In most cases, policy agendas are adapted incrementally, in response to evolving circumstances or different understandings of the impacts of existing policies — so called 'politics-as-usual' (Grindle and Thomas, 1991). A relatively stable group of actors are involved in policy development, following well-established, institutionalised procedures. In a minority of instances, however, economic, political or social crises call for more radical policy shifts. External events make it glaringly apparent that existing policy measures are inadequate and/or unsustainable. As discussed in the previous chapter, HIV/AIDS can be viewed as an example of a policy crisis (Day and Klein, 1989). Yet the fact that it was in many ways out of the ordinary, did not mean that every sort of policy option would

be given equal consideration. The nature and scale of a country's government organisations have a significant impact on the way in which policy agendas are set. The organisations and systems in place to monitor a particular issue area will tend to 'look for' answers to problems that reflect a particular view of the issue. In Britain, for example, the government response to HIV/AIDS was heavily influenced by the fact that it had an established public health system and an extensive infrastructure of anonymous Genito-Urinary Medicine (GUM) clinics (Berridge, 1996: 25). These organisations dealt with the emerging problem of HIV/AIDS within a long-established set of values and a belief in the utilitarian benefits of offering anonymous testing and treatment.

- *Formulation*

This is the stage at which policy-makers define their objective and make decisions about the instruments they will use to achieve it. In many cases, this will involve decisions about which government bodies will be responsible for its implementation. In other cases, there may be a decision to delegate responsibility to non-government bodies, with the government retaining only responsibility for support and review.

Some rationalist approaches assume that the agenda-setting and formulation phases of the policy cycle are essentially technical. Particular problems are identified by empirical observation and their solutions identified by scientific analysis. This conception under-estimates the political complexity of the way in which 'problems' are articulated (Majone, 1989: 15). The nature and hence the potential solution to problems is often the subject of great debate. A key function of interest groups is to attempt to influence the way that state organisations view particular policy problems (Grant, 1995). Nor can it be assumed that, even once a particular problem has been put on the agenda, scientific analysis will necessarily offer a single, unambiguous and objective picture of the problem (Majone, 1989). Organisations may therefore commit substantial resources to influencing the way that problems are defined, using evidence and argument to 'persuade' decision-makers that theirs is the most appropriate way of conceiving a particular problem.

- *Legitimation*

The process of legitimation is the stage at which the legal framework is adjusted so as to define who are the proper targets of a policy, and under what legislative conditions. This is a critical stage of the policy process, and one that can radically affect subsequent policy development. This is particularly true in low-income countries that have relatively weak legal infrastructures. One criticism of economic planning in developing countries during the 1960s and 1970s, for example, is that governments failed to enact legislation that would have made it possible to implement policies effectively. Thus, elaborate national plans remained largely symbolic, little more than a general 'wish list' (Agarwala, 1985).

- *Organisation*

At the organisation phase of the policy cycle, policy-makers make decisions about how policies are to be administered and who is to implement them. In many cases, a particular government department may be held responsible for implementing the policy. In others, policies may be contracted out to independent, non-government organisations, with government retaining only a supervisory role. Decisions made at the organisation phase of the policy cycle will have significant implications for the way in which policies are subsequently implemented.

- *Implementation*

In the classic state-centred approach, the implementation stage is viewed as being overtly political. The various organisations involved in implementation have capacities to affect the way in which policies are interpreted and enacted (Pressman and Wildavsky, 1979). At every stage of the policy cycles, organisations and individuals have different capacities to 'veto' policy development (Grindle and Thomas, 1991).

- *Evaluation*

In a rationalist ideal-type, mechanisms for evaluation should be firmly built into policy design. The criterion by which a policy can be judged to have succeeded or failed should be agreed and an evaluation process pre-scheduled. Evaluation can take different forms, from internal organisational reviews, to scrutiny by

independent bodies or interest groups. Evaluation may also take unplanned and unofficial forms in public discontent or media interest.

Being poorly understood and incurable, HIV/AIDS presented an evaluation problem for policy makers. An inoculation programme, for example, can be easily evaluated based on the numbers of the target population who have been inoculated. A programme's ultimate success would occur when the disease was eradicated. AIDS interventions, however, are based on rather more abstract courses of action: education campaigns designed to alter the way people behaved and how they perceived the problem. Here the goal is to try to affect the rate of transmission. This is a much more problematic goal as it involves complex issues such as how to gauge behaviour change accurately and how far any change was directly attributable to policy interventions.

- *Termination*

Rather than being infinite and linear, policies are inevitably succeeded by fresher formulations, or policy 'succession'. The notion of the policy 'cycle' was developed specifically to emphasise how policies have a certain life span before they are adjusted and reformulated. The duration of the policy cycle, however, will depend on the its nature and on the political context. Majone (1989: 150) describes policies as having a relatively stable 'core', of shared assumptions, methods and goals that are central and only abandoned after great stress. At the periphery, however, are various more transitory policy end products, which will be reviewed with greater frequency.

ii. Top-down models and trans-national policy

Top-down models of policy-making have been used to examine attempts at trans-national policy implementation. Wihtol (1988), for example, uses the notion of the policy cycle to examine and explain the sub-optimal implementation and unintended consequences of the Asian Development Bank's (ADB) rural development policies. The ADB, a multilateral development bank funded primarily by the developed market economies, was faced with the challenge of implementing an effective

lending programme in developing countries aimed not only at promoting economic growth, but also at alleviating poverty in rural areas. Wihtol breaks down its policy evolution into five core stages, revealing a series of conflicts between the policies and priorities of the three key groups involved in the policy: the ADB, donors and borrowing governments. Donor preferences played a dominant role in shaping the Bank's overall development policies, which were regularly reviewed and changed considerably over the period studied. Over time, donors began to place more emphasis on poverty alleviation and rural development, rather than simply increasing the country's GDP. On a more day-to-day level, however, operational policies and organisational constraints made it difficult for bank personnel to implement these policies. As an organisation, the ADB was structured around the importance of achieving annual lending/disbursement targets and administrative efficiency. This meant that bank executives favoured projects which were large, temporally defined and easily-managed at the expense of longer-term programmes which may have tackled poverty more successfully and which were more in accord with the ADB's overall objectives.

The advantage of state centred or 'top-down' approaches to understanding the policy process is their conceptual clarity. The life span of a particular project or policy provides an organising logic around which to explore how organisational or political factors may facilitate or impede policy implementation. Such approaches do, however, have associated weaknesses. In the first place, they tend to focus on central decision-makers, thereby neglecting strategic initiatives from other agencies, the private sector or implementing officials (Barrett and Fudge, 1981: Introduction). One of the criticisms of 'top-down' approaches is that they are difficult to use in situations where there is no one dominant policy (statute) or agency in place, but rather a variety of government directives, agencies and actors, none of which are pre-eminent (Barrett and Fudge, 1981). The Global AIDS Strategy falls into this category. Though it is a single resolution, its very design incorporates a variety of different government and non-government agencies with no clear hierarchy between them. Though the WHO/GPA was nominally in charge, it had no effective power to enforce implementation — one of the basic tenets of the UN system is that individual states are sovereign and that UN

agencies can not launch interventions without the express permission of the government in power. Yet within this inter-organisational web, there are asymmetries of resources and power. The Strategy was signed by a range of individual states, many of which were small, impoverished and dependent on international agencies for funding. Other signatories were well-resourced and had elaborate AIDS programmes in place prior to signing the agreement. This type of asymmetry will influence the relationship between different organisations and must be addressed explicitly if we are to understand the WHO/GPA's influence in particular circumstances. The second weakness of state-centred approaches is that they tend to over-emphasise the 'rationality' of decision-makers. In a sense, these are similar arguments to those levelled against realists. In practice, individual organisations can be riven by disagreement; actors may have no clear conception of the problem or how to tackle it.

B. The 'garbage-can' model

The foremost account of the international response to HIV/AIDS rejects top-down approaches and instead adopts a 'garbage can' model to explain the complex interactions of national and international organisations as they responded to the growing AIDS problem (Gordenker, Coate, Jonsson, and Soderholm, 1994). The garbage can model counters the perceived tendency amongst policy theorists to over-emphasise policy-makers' ability to design and implement rational policies. The main focus of the garbage-can approach is on organisations, rather than individuals, and it is based upon three fundamental observations. The first is that decision-makers often operate without any clearly defined objectives. Organisations can be seen as loose collection of ideas, establishing preferences through experience rather than working on the basis of a unitary set of principles (Cohen, Mar and Olsen, 1972). Secondly, it is argued that the workings of an organisation are often unclear. Few people have a sound grasp of the way in which their organisation works as a whole; their understanding is patchy and localised. The final observation is that decisions are rarely made by a consistent set of actors. Different people and interests become involved at different stages of the decision-making process.

From this original set of observation, Cohen *et al* (1972) argue that problems, solutions, participants and decision-making opportunities are semi-independent factors, all of which impact upon the policy process in different ways. Policy decisions can be seen as the outcome of the particular collision of these factors. In other words, policy development is irrational and unpredictable. Gordenker *et al* (1994) use this 'garbage-can' model to emphasise the often random process of international collaboration on AIDS issues. The authors contend that HIV/AIDS provided policy-makers with a complex and technically insoluble problem. Far from being a 'rational' process of optimal decision taking, policies evolved sporadically, the result of competition between organisations to claim authority in a conceptually troublesome field. The authors argue that the probable survival of proposed policy solutions depend on at least three criteria. The first is technical feasibility — only ideas capable of effective application can survive. The second test is that of value acceptability — successful solutions have to accord with the values held by policy-makers. The third criterion of survivability is the 'anticipation of future constraints'. Policy-makers take into account the obstacles that alternative proposals are likely to face and make policy choices accordingly. With AIDS, the absence of a cure or vaccine made other, educational and social solutions more prominent. Yet, in the absence of purely technical solutions, alternatives such as sex-education, needle exchanges and condom distribution challenged deeply held values of policy-makers and public alike.

Given this complex policy environment, the authors argue that one key factor could have enabled one particular conceptualisation of a problem to win out over others: the development of a vivid metaphorical formulation of the problem. The UN General Assembly's formulation of the seabed as 'the common heritage of mankind' for example, is said to have framed negotiations on the law of the sea for years. In contrast, it is argued, no clear, consensual formulation of HIV/AIDS emerged and as a result, policies developed in sporadic and often contradictory directions.

Gordenker *et al's* approach provides a detailed review of international attempts at co-operation, yet it has certain weaknesses. In the first place, it is only an overview and its focus is on the dominant inter-governmental and non-governmental international organisations. This at times leads to some confusion about the level of analysis at which the study is operating. In many respects, the analysis operates at the extreme macro-level in its discussion of large-scale international movements. In their chapter on Third World bargaining, for example, the authors do not analyse negotiations between groups in individual countries. Instead, they focus on general trends in donor policies and organisational adaptation within donor and international organisations. In the process of examining these interactions, however, the authors inevitably get drawn into detailed analysis of inter-personal and inter-organisational relationships. Changes in policies or organisational reshuffles are explained by reference to individual perceptions and/or competition between organisations. The result is that the analysis swings uncomfortably from global movements to personal disagreements, with no explanatory analysis of policy developments at a country level.

A related weakness of the book is its failure to show how historical and structural factors may impact upon the extent to which particular ideas hold sway. In many ways, this appears to be a limitation of the somewhat mechanistic and ahistorical 'garbage-can' model. In this construction of the policy process, policy agendas are likened to bins into which participants dump problems and solutions in various forms and at different speeds of collection and removal. This model was developed to counter undoubtedly simplistic notions that policy choices are the result of informed and rational deliberation, yet in eliminating one simplification, the model introduces others. Though the authors state that problems, solutions, participants and choice opportunities are only 'relatively' independent, in practice they are implicitly presented as existing in isolation from each other and from a wider historical and ideological context. There is little discussion of how differences in participants' resources impacted upon policy negotiations, for example, and little attention is given to how wider historical processes influenced the various contents of the policy 'bins'. The model implies that policy outcomes are the product of a type of political free market, in which ideas, participants, solutions and problems all

vie for ascendancy. In practice, all these factors are constrained by a prior history of previous choices and power relations.

Gordenker *et al's* approach is a useful antidote to overly rationalist policy analyses. However, the fact that it only discusses the relationship between major international organisations makes it difficult to draw any wider conclusions about policy development as a whole. It can not explain how individual state and sub-state organisations interact with this web of international organisations. More importantly, it tells us nothing about power in the international system. International organisations are seen as competing against each other in a political vacuum. It cannot explain how differences in relative power affect the relationship between international and national organisations.

C. Society-centred approaches

Society-centred, or 'bottom-up' approaches to understanding the policy process reject the assumption that policy is decided by the higher echelons and then simply put into practice by those lower down the hierarchy. The assumption that there is a clear distinction between policy-making and policy implementation is regarded as being naive (Majone and Wildavsky, 1978). In practice, lower-level workers have the ability to exercise discretion in the application of policy. They can resist or alter policy decided by those at a higher level and act in ways which conflict with higher level policy declarations. Policy-making is seen as an iterative, political process, between those who seek to put a policy into effect and those who must implement it.

This approach to understanding the policy process has significant methodological implications. Where top-downers focus initially on a (central) government decision, 'bottom-uppers' look first to the local implementation structure involved in a particular issue. They then identify the network of actors involved in service delivery in a particular area, and ask them about their goals, strategies, activities and contacts (Hjern *et al,* 1978). Such an approach offers some advantages over top-down methods, especially in a trans-national, multi-agency policy arena such as

that within which the Global AIDS Strategy was operating. Instead of focusing on the attainment of formal policy objectives, the approach can reveal the (unintended) consequences of policy programmes. It is also better equipped to deal with policy areas involving a variety of public (and private) programmes than state-centre approaches. Methodologically, it provides a more exhaustive, systematic framework of analysis than the garbage-can approach.

The bottom-up approach does, of course, have disadvantages. In the first place it focuses on peripheral actors' goals and strategies. In doing so, the approach can underestimate the centre's ability to frustrate the periphery and its *indirect* influence on peripheral actor's goals and strategies (Sabatier, 1986). The second criticism is that its heavily contextual approach makes theoretical generalisation and policy evaluation very difficult. If policy is constantly adapting, policy evaluation, rather than simple description, becomes impossible (Sabatier, 1986).

This criticism is particularly relevant to the study in hand. The purpose of this study is to look at the broad impact of an international resolution and the organisations it generated over an eight-year period. While it might, theoretically be possible to do an exhaustive review of the inter-personal and inter-organisational dynamics involved at every stage of implementation in individual cases, such a study would not say very much about international collaboration in general. Neither would it acknowledge sufficiently the dramatic imbalances of power between the range of organisations affected by the strategy. Only from one step removed is it possible to see how the overall organisational and political landscape affects the range of options available to policy-makers and the development of policy.

2. Policy network theory

In the previous section, I reviewed the main ways of approaching policy analysis. State-centred approaches provide a framework for conceptualising the policy process, including the ways in which external factors may influence policy development. They are, however, weaker at understanding situations — like the

Global AIDS Strategy — in which responsibility for policy development falls across a variety of different organisations. They also tend to over-emphasise the rationality of policy-making, failing to acknowledge the way that different values and sets of assumptions are built into the organisations responsible for developing policy. 'Garbage-can' models of policy-making emphasise this unpredictability of policy development yet are weakened by a compensatory over-emphasis on its randomness. The relative influence of organisations is dependent on broader historical factors, which give some groups greater access to central decision-making bodies and makes some policy approaches more 'acceptable' than others. Society-centred approaches provide a methodological framework for analysing the influence of a broad range of groups and (unexpected) impacts of policy, but are weak at analysing structural inequalities between groups.

The Global AIDS Strategy was a trans-national policy initiative, involving a variety of organisations with no clear hierarchy between them. Policy analysis can provide a framework for describing in detail the way in which policies evolved and their various effects. However, in order to begin to explain the relative influence of different groups involved in developing HIV/AIDS policies, it is necessary to develop a meso-level conceptual framework that takes into account the various actors involved in the policy process, but which acknowledges differences in their relative influence. It is also necessary to look at how historical and economic precedent impact upon the way groups are organised and their relative influence.

In this section, I will argue that policy network theory provides such an approach, offering a means of describing the relationships between groups in particular policy arenas and explaining how these affect policy outcomes. The underlying argument behind policy network theory is that in order to understand policy outcomes, it is first necessary to understand the relationship that exists between groups and the interests and activities of state actors (Smith, 1993). The theory first emerged as a critique of pluralist accounts of the policy process, in which policy outcomes are seen as the result of group pressures. In the American pluralist literature, groups are seen as the means of articulating the interests of various sectors of society and representing those interests to a relatively neutral state. The state's role is to

balance the competing pressures of these different groups. Critics, however, observed that is certain circumstances, small groups of members of Congress and/or Senate, legislative agencies and pressure groups were developing a symbiotic relationship, forming a sub-government which effectively excluded other participants from the decision-making process (Lowi, 1979). These 'iron triangles' are presented as being an obstacle to full and proper political participation, an imperfection in the pluralist free market.

Since then, the term 'network theory' has been used in a number of different ways, from describing close interpersonal relationships within an organisation, to political manoeuvring on the national stage. The result has been a proliferation of terminology, with the same terms being used by different writers to describe rather different concepts (Rhodes, 1990). Policy network has, for example, been used to describe relations between individuals within organisations (see Wilks and Wright, 1988). It has also been used very loosely to describe "actors and potential actors who share a common identity or interest" (Wright, 1988: 606). Such definitions offer little explanatory insight into how actors relate to each other, and what effects these relationships have on policy.

For Smith, policy network theory is an intermediate or meso-level theory that is potentially compatible with Marxist, Pluralist or Elitist understandings of political power (Smith, 1993: 233). Its usefulness lies in its ability to describe and explain underlying inequalities in group dynamics. A policy network can be defined as a "cluster or complex of organisations connected to each other by resource dependencies and distinguished from other clusters or complexes by breaks in the structure of resources dependencies" (Rhodes, from Smith, 1993; 58). Thus, policy networks can be distinguished from an 'issue network', which encompass all the groups that may potentially be involved in the policy process and which have limited or no interdependency and varied resources and capabilities.

Table 2.1 The Characteristics of Policy Networks

1. Membership	*Policy Network*	*Issue Network*

Number of participants	Very limited, some conscious exclusion	Large
Type of interest	Economic/professional	Wide range of groups
2. Integration		
Frequency of interaction	Frequent, high quality	Contacts fluctuate
Continuity	Membership, values, outcomes persistent	Fluctuating access
Consensus	All participants share basic values	A degree of agreement, but conflicts present
3. Resources		
Distr of resources within network	All participants have resources Relationship one of exchange	Some participants have resources, but limited
Distribution of resources within participating organisations	Hierarchical leaders can deliver members	Some participants have resources, but limited
4. Power		
	There is a balance among members. One group may be dominant but power is positive-sum	Unequal power. Power zero-sum

Adapted from Rhodes and Marsh, 1992: 187.

Rhodes and Marsh (1992) argue that networks vary according to four main dimensions (*see table above*). The first dimension is that of membership. Policy networks may be made up of state and/or private organisations. Professionals may be included, whether as individual experts or as organised groups. Policy networks may deliberately exclude other groups. In order to participate in day-to-day policy making, members must abide by the 'rules of the game' and must be perceived as being 'sound' and qualified. If an organisation seeks to engage in illegal demonstrations to make a political point then it could be excluded from official policy discussions (Grant, 1995: 19). The second dimension is the extent to which networks are integrated. In a policy network, members meet frequently and engage in detailed discussion. Members share values and policy outcomes are relatively persistent. All the participants share the same basic values. The third dimension is the way in which resources are distributed. In a policy network, all participants have resources and their relationship is one of exchange. In an issue network, resources are unevenly distributed.

The final dimension to influence the relationship between groups is that of power. In a policy network, all members have power and power is positive sum: their relationship actually increases their collective influence. By joining forces, they can act to exclude other groups from the policy process or to achieve particular ends. In an issue network, power is distributed unevenly and is zero-sum. If one group gains more power, it will be at the expense of other groups in the issue network. The relative influence of a network will depend on its power relative to other state networks and to state organisations immediately above it. In some circumstances, the government or head of state can over-ride the wishes of a policy network.

Policy network theory can be used to show how groups operate on a national and international level. It recognises that different groups may influence policy, but that the extent of their influence is largely, though not entirely, path-dependent. In certain circumstances, such as the policy crisis presented by AIDS, it may be possible for normally relatively peripheral groups to influence the course of policy. This approach to policy network theory assumes that the state has an interest in developing integrated relationships with other groups as a means of increasing its influence and that these relationships affect policy outcomes. Thus, it has explanatory as well as descriptive value. Essentially, the approach is based on three key premises. Firstly, that some groups have structural advantages over others. Secondly that the state is an influential, and often under-estimated actor. Thirdly that, rather than acting in anarchic opposition, groups can actually increase their influence through forming networks.

A. Structural advantage

It is widely accepted that in any inter-group dynamic, certain organisations yield more influence than others and, other things being equal, their interests will be most consistently represented in policy outcomes. Pluralists have long conceded that well-resourced groups can have a disproportionate influence over government. In the US, there is considerable anxiety about the relative power of lobbyists. Thus, pluralist studies of group interactions focus heavily on differences in financial and administrative resources, the argument being that prosperous, well-organised

interest groups are in a stronger position to lobby government effectively and thereby influence policy outcomes. According to policy network theory, which has been more influenced by European sociological traditions, it is not enough to look just at the resources of different groups. The financial and organisational resources of a group are not the sole determinants of its influence. As Smith (1988: 4) memorably observed, the British labour movement had as many resources on May 2, 1979 as they had on May 1. But the Conservatives party's electoral victory radically reduced its influence over-night. According to network theorists, it is important to look at the context within which groups operate.

It is therefore necessary to consider the vexed question of power. In this thesis I will use it in an inclusive sense, as "the ability of a person or group to affect outcomes [so] that their preferences take preference over others" (Strange, 1996: 17). This definition avoids the problems created by attaching power to the pursuit of individual, state or class 'interest'. The term 'interest' is inherently problematic, it being contestable that a collective entity such as the state, could identify, prioritise and pursue an objective 'interest'. State agencies may be in disagreement about their interests, or be mistaken about how to achieve ones they have identified (Skocpol, 1985). A second problem with the term 'interest', more specific to the study in hand, is that it implies that decisions are necessarily taken with an explicitly self-interested motive. This study analyses an ambitious attempt at international co-ordination in the face of a serious health problem. In some cases, the impact of WHO/GPA's interventions was limited and even negative. Though some authors have suggested that 'development' agencies have an interest in reproducing poverty (Rajab, 2000) this study reveals no evidence that sub-optimal policy outcomes were the result of systematic or malicious self-interest. On the contrary, many individuals in the WHO/GPA, governments, civil service and NGOs were personally and professionally committed to addressing a serious and intractable problem. However, structural constraints affect the context within which policies are formulated and implemented. Equally, decisions about how to prioritise objectives and how to organise and implement projects reflect most closely the values and priorities of influential groups. This can in turn affect policy outcomes, to the detriment of poorer project 'stakeholders' (McGregor and

Laurence, 2000). Strange's definition simply asserts that in any particular situation, groups may have particular preferences as to how to achieve particular goals and that those who have power will be able to assert that preference over others.

Jessop identifies two forms of power (1980). The first is direct or agency power, the ability of A to get B to do something he would not otherwise do. This may take the form of coercive violence or force. As I have already argued, this aspect of power is of limited relevance to the Global AIDS Strategy, which was voluntary and ultimately based on the UN's principle of the sovereignty of states. Agency power may also, however, take more subtle forms, in strategic skills. Those groups who are able to develop and deploy ultimately persuasive arguments have access to a form of power. In certain circumstances, individuals or organisations can use superior analytical, economic or political resources to assert their preferences over others.

The second form of power, is *structural* power, the power to "shape and determine the structures ... within which other states, their political institutions, their economic enterprises and (not least) their scientists and other professional people have to operate" (Strange, 1988: 24). While direct power may be the ultimate sanction, day-to-day dealings between separate parties are more constrained by the rules, norms and expectations of the most powerful. In any group dynamic, therefore, certain groups may have *structural* advantages over others. These advantages are not created by the deliberate acts of individuals or groups, but develop over time as the result of a whole range of acts, intended and unintended consequences and the repetition of routines (Giddens, 1986). Being deeply embedded, these advantages can not be changed by the decisions of individual actors.

Smith (1993) argues that in order to understand the relative influence of groups, you have to understand the context within which they operate. A group's relative influence is determined by three factors: history, ideology and organisation. Historical factors influence the esteem with which groups are held, their resources

and their institutionalised access to the policy process. Ideology plays an important role in the way that groups are perceived and what policy options are conceivable. In any given policy sector, core values will affect policy-makers' perceptions of problems and hence limit the number of 'solutions' that are considered appropriate. The increasing acceptance of the free-market ideology since the 1970s, for example, has radically affected policy development in many state and international organisations (Strange, 1988: 185). Finally, the way policy-making bodies are organised also impact on the relative influence of groups. Some procedures favour certain interests over others because they provide access to only a limited number of groups, or favour a limited set of solutions. The organisation of the policy network creates institutions that include or exclude groups (Grant, 1995).

Structural power confers the ability to decide how things are done and to shape the way individuals and groups relate to each other. Strange (1988: Chapter Two) argues that all contemporary human relations, whether at an individual, national or inter-state level, can be viewed in terms of differences in structural power. Structural power, she argues, resides in four separate, distinguishable but related structures: security; production; finance and knowledge. Thus, power lies with those in a position to exercise control over people's security and with those who can decide and control the manner or mode of production of goods and services. In the international arena, an increasingly important source of power stems from the ability to control the supply and distribution of credit. This facet of power, she argues, tends to be over-looked by traditional Marxists, who emphasise the significance of the production function. Modern capitalism, she argues, is developing too quickly to be financed solely by the accumulation of profit. Credit is a vital component for economic growth and those who decide how it is to be allocated have a significant influence on the parameters within which businesses and governments must operate. This facet of power is of particular relevance to contemporary international relations, when a majority of states are heavily indebted to individual governments, commercial banks and multi-lateral institutions, such as the World Bank.

Finally, access to the control and production of knowledge is a form of structural power. Those who can control the way it is acquired, disseminated or withheld – whether through education, the media or government – wield power. Strange's conception of the 'knowledge structure' includes what is believed, what is known and what is perceived as understood. It also includes the channels by which beliefs, ideas and knowledge are communicated (Strange, 1988). The knowledge structure determines what knowledge is discovered, how it is stored, who communicates it by what means and on what terms. It is also the aspect of structural power that is undergoing the most change. Innovations in communication systems have a substantial influence over the distribution of knowledge. Over the last century, improved communications have allowed for a far greater centralisation of power. In the past fieldworkers, especially in geographically remote areas, had a significant degree of autonomy. Central government could not find out about local conditions quickly enough to make day-to-day decisions, which were thus the responsibility of local staff (Strange, 1988). Developments in information technology have allowed central government more direct control of a greater number of issues.

One important way in which structural power in the knowledge structure is preserved is through the existence of a supportive underlying belief system. For centuries, the Catholic church's authority was underpinned by the belief that it alone could provide salvation (Strange, 1988). Equally, the influence of contemporary organisations such as GATT and the World Bank are supported by the underlying belief that free trade and non-interventionist government is the most effective way to long-term economic development.

B. The significance of the state

Policy network theory sees the state as having a significant role in policy-making in its own right. For traditional Marxists, the capitalist state's role is essentially to ensure the long-term interests of capital in the face of opposition by organised labour. Essentially the state is subordinate to the interests of the representatives of capital, and is only able to act independently in times of real crisis, when war or

economic depression divides political opposition and creates opportunities for policy changes (Block, 1980).

To some critics, the idea that the state has autonomy is incompatible with policy network theory which, they argue, is a development of pluralism (Jordan, 1990). To pluralists, the state is simply the mechanism by which societal wishes are mediated and enacted. More recently, however, there has been re-emphasis on the state, with theorists arguing that as a powerful and well-resourced body of organisations, the state has the means to influence the context within which other groups operate. The state and state actors have interests and capacities of their own and, in certain circumstances, the ability to translate those interests into policy. For Cerny (1990) the state has a significant influence over the structure of society, and therefore it cannot be accurate to say that society determines the interests of the state. Similarly, Nordlinger (1981) argues that the preferences of the state are at least as important as those of civil society and that the state can act according to its own preferences even when they diverge from those of the most powerful in society. Nordlinger identifies three types of state autonomy. Type I autonomy occurs when state and societal preferences diverge, and state officials act according to their own preferences ignoring societal wishes. Type II occurs when societal preferences differ from those of the state, but public officials use argument and persuasion to bring about a shift in societal perceptions. Finally, type III autonomy occurs when a state agency pursues a course of action that is in accordance with public opinion, but does not do so *because* it is popular. In other words, it would have pursued that course of action irrespective of public opinion. Analysts, he argues, tend to confuse a *correlation* between state and societal wishes with *a causal relationship*.

Unlike realism, 'the state' is not seen as a unified actor but rather a loose association of relatively distinct organisations including government, the civil society, the judiciary, parliament and local government (Hall and Ikenberry, 1990). The state is seen as a site of conflict, in which various sub-sections of the state compete for resources (Skockpol, 1985). Together, this set of organisations and rules provides the broad parameters of conflicts over the use of resources and the

direction of policy. State actors are also seen as having distinct interests of their own (Weir and Skocpol, 1985). State interests are not reducible to class interests and the state may take actions against the preferences of capitalist classes, as Skocpol (1980) demonstrated in his discussion of the United State's New Deal. State agencies are interested in their own survival and preserving their influence relative to other organisations. They will also develop their own procedures and organisational values, which will influence their perception of policies. Different role-holders may have different interests. Elected state actors have an interest in re-election, while bureaucrats may have a greater interest in minimising the problems and unpredictability of policy implementation (Smith, 1993: 50). However, they also have some shared goals, such as internal order, state legitimacy, external security and economic growth.

Thus, state policies are often the result of conflicts between state organisations, rather than collective action by 'the state'. The expression 'state actions' is therefore just shorthand for individuals within particular organisations acting, and not an assertion of collective action on the part of an abstract body. The activities of these agencies are, however, constrained by their particular roles, defined as clearly articulated bundles of rights, duties, obligations and expectations (Knoke, 1990: 7). Ultimately, therefore, decisions are made and actions taken by individuals acting within organisational roles. The role of groups, therefore, is often to support the most sympathetic state agencies, rather than acting in direct conflict with 'the state'.

The ability of state actors to put their preferences into action depends on their capabilities. A state may chose to use force to overcome political opposition, as the Chinese government did in Tiannamen Square in 1989. The problem with using despotic power, however, is that it is almost certain to prove expensive in the long run, tying up resources in military and para-military organisations. It also creates conflicts internally and with the international community. A more effective use of power is to use the state's ability to penetrate civil society in order to implement political decisions. The state has resources, administrative machinery and controls most essential services. It therefore has the ability to intervene in

society, creating expectations, influencing opinions and affecting the environment in which other groups operate. The state is fully centralised over a clearly defined territory. It therefore has a strategic advantage over other groups, who will be dependent on it to provide an infrastructure (Smith, 1993: 53).

C. Consolidation of power through reciprocal exchange

In pluralist theory, power is seen as being zero-sum. Groups compete for power, and one group's gain must necessarily be at the expense of another's. Similarly, in Marxian analyses, the state is only able to achieve limited autonomy where opposition groups are divided. In network theory, however, the state actually gains power from building relationships with other groups. By working together, the state and civil society organisations can achieve greater autonomy from other parts of the state and gain greater control over the policy process. Relationships between members of a policy network are therefore seen as being one of exchange, with different groups trading financial, technical or political support in a reciprocal exchange. Policy making, therefore can be seen as a game in which both "central and local participants manoeuvre for advantage, deploying their constitutional-legal, organisational, financial, political and informational resources to maximise their influence over outcomes" (Rhodes, 1990: 10).

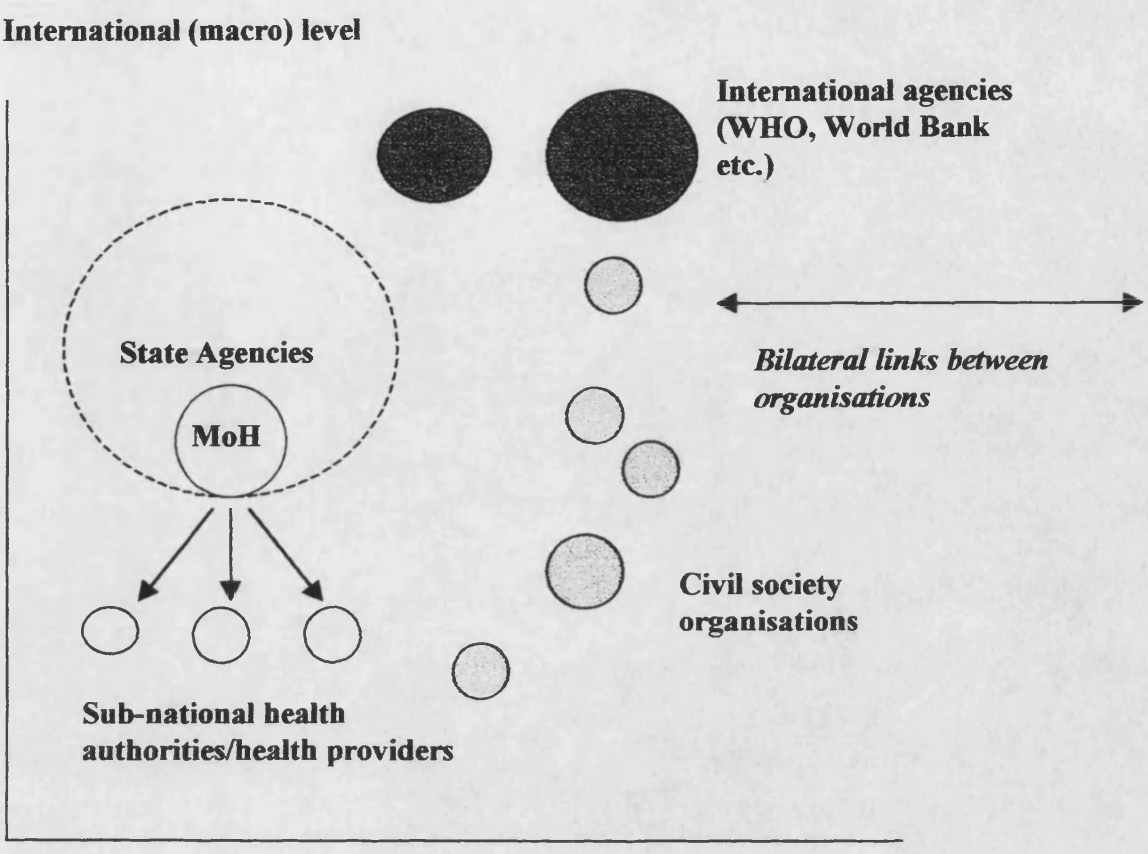
Most models of inter-organisational politics view relationships as being one of conflict. Policies are negotiated through the opposition of different groups. In fact, the lines between state and society are blurred and it is sometimes difficult to make a meaningful distinction between the two sectors. Many non-government groups have state sponsorship, or are given regularised access to policy negotiations. Similarly, state actors are members of a wider society; subject to many of the same social, economic and cultural influences. It is therefore all the more useful to see power as being positive sum, sometimes growing through collaboration between groups, not necessarily being diminished by opposition from others (Smith, 1993: 73).

3. Health policy in an international context

The aim of the Global AIDS Strategy was for international, state and non-government organisations to collaborate in the implementation of a globally homogenous response to HIV/AIDS. Policy network theory has not been used to examine the process of international policy co-ordination and this section I will provide an overview of the different organisations that are potentially involved in the implementation of international policy agreements in the health arena. If the Global AIDS Strategy was to be implemented successfully, its policy recommendations would have be negotiated at a national level, then implemented by national organisations. As I have argued, policy-making can be seen as a political process, involving negotiation and bargaining between conflicting interests. Policy development will reflect those interests, but will also be influenced by prior policies, the resources available, expected resistance to particular policies and the historical relationship between key organisations.

The figure below maps out the organisations that would have been involved if the aims of the strategy were to be achieved in the way undertaken by signatory governments. Though the relationships between these organisations would vary from country to country according to its political and socio-economic history, the basic organisational landscape is likely to have been broadly similar. The diagram is intended as a basis for drawing comparisons between the way the WHO/GPA impacted upon national organisations in different contexts. The case studies in the following chapters will go on to explore differences in the relationships between these organisations and how this impacted upon HIV/AIDS policy development.

Figure 2.1: Mapping the health policy environment



A. Macro level: the international community

National governments do not act in a vacuum and are affected by international agreements and international organisations. International organisations, which may be regional or global in remit, are defined as one whose membership, finance and field of operation involves two or more member states. The current UN system — of which the WHO is one part — was established by charter in October 1947 and bore the strong *imprimatur* of the US and the Western industrialised states that funded it. It was based on the principle of state sovereignty. Individual member states retained sovereignty within their own borders. Since the mid-1960s, the newly independent states have greatly increased the UN's membership at the same

time as expanding the remit of its specialised agencies. These agencies — which include the WHO — were originally established to provide a clearinghouse of information in their areas of expertise and to advance international standardisation. After 1950, they gained a more direct role providing technical assistance and funding to low-income countries (Williams, 1987: 14). These organisations are purposive bodies that have resources, interests and capacities in their own right (Gordenker *et al*, 1994). Increasingly, they also have a direct impact on the way policies are developed, particularly in low-income countries (Walt, 1994: 122).

International organisations operate within a wider framework of international agreements and understandings. These I will term international institutions, where institution is defined as "persistent and connected sets of rules, formal and informal, that prescribe behavioural roles, constrain activity, and shape expectations" (Keohane, 1990: 732). In other words, actors' behaviour in the international context is to some extent circumscribed by the expectations of the existing international regime. Aberrant behaviour is likely to be met with repercussions in the form of deteriorating relations with other states, or political or economic sanction.

The WHO is a specialised agency of the UN, with responsibility for health. The organisation is made up of 178 member states, an executive board and a secretariat. Member states meet at the World Health Assembly for two weeks every year. The executive board, consisting of about thirty elected representatives, meets before and after the assembly to discuss policy directions in more detail. Thus, state representatives have some opportunity to influence its overall policy. The WHO secretariat is composed of the Director General and permanent paid staff and is responsible for its day-to-day operations. Staff are meant to be politically neutral but are often national political appointees and keep in close contact with their country's embassy (Walt, 1994: 132). The Director General has significant influence within the WHO, formally appoints all other staff and has authority to move them from department to department.

The WHO was originally funded by a regular budget donated by its members. Increasingly, however, it has become reliant on extra-budgetary or voluntary funding. This has grown from 25% of total funding in 1971 to approximately 54% in the early 90s (Walt, 1994: 135). The GPA, which was created to implement the Global AIDS Strategy, was one such extraordinary programme. According to some, this change in funding patterns has altered the balance of power within the organisation, giving relatively more power to a handful of donor governments making *ad hoc* decisions about who to support rather than developing strategic policies (Walt, 1994: 136).

The WHO/GPA were just one among many international organisations who had a potential interest in HIV/AIDS policies. In addition to the other specialist agencies of the UN, there are regional organisations, such as the European Commission, the executive body of the European Union. Many of these organisations were developing policies in the area whilst the strategy was in operation. Gordenker *et al* (1994) give a detailed description of the various approaches to HIV/AIDS that were being pursued in the late eighties and early nineties and the organisational competitiveness this sometimes provoked.

In addition to formal international organisations, many national organisations have bilateral links with organisations in other countries. National research institutes often work collaboratively with other organisations, for example. State actors draw from the experiences of other countries when they develop their own national policies. These bilateral links are particularly important in developing countries. Much aid is given by bilateral agreement and donor countries maintain close links with the governments to which they give money, overseeing the way it is disbursed. In many low-income countries, ministry business is strongly influenced by the donors who support policy changes and provide expert consultants (Cliff, 1993).

B. Meso-level: national organisations

i. 'The State'

Though the international relations literature often refers to 'the state' as a homogenous entity, empirical observation reveals it to be a heterogeneous ensemble of separate agencies, each with its own resources, strategies, procedures and priorities. Most contemporary states comprise of a legislature, an executive and an administration. The legislature is the supreme policy-making body, and is usually deemed to have three functions, to represent the people, to enact legislation and to oversee the executive. Elected representatives have constitutionally established responsibilities, and they are often the most immediate focus of public dissatisfaction, should policies 'go wrong'. Increasingly, however, they are seen as being relatively ineffective, 'rubber-stamping' decisions that are made by the executive. Healey and Robinson (1992) argue that the legislature's role is marginal. The executive keeps a strict control of their activities through the use of patronage and party discipline. Supra-national bodies like the EU also limit legislature autonomy. Most, however, retain the ability to debate, adapt and even block proposals. Members of the legislature may also derive some power from their ability to attract publicity and embarrass government.

In most states, considerable policy-making power resides with the executive, a senior-level sub-section of the legislature normally including the premier and ministers (deputies or senators), who have responsibility for particular policy sectors. The power of the chief executive, relative to other members of the executive and other parts of the state varies over time and between states. In many parts of the world, particularly Africa, the rule of the chief executive is often personal and unaccountable (de Sardan, 1993; Bayart, 1993).

The 'administration', or civil service, can be extremely influential. Without the administration, the executive could not function. Its influence will depend on the organisational and political context. In some countries, like the UK, the administration is stable and expected to be neutral. Much of its influence is derived from its representative's expertise and experience. When ministers arrive in office they frequently know little about their new portfolio and have to be guided by the

administration. Headey (1974) argues that the minister's role is often minimal, confined to making marginal choices, improving efficiency and acting as an ambassador for policy developments. British politician Michael Meacher has argued that civil servants' knowledge and experience gave them considerable opportunities to minimise minister's influence (1980). In the other regimes such as the US and most of South America, senior administrators are political appointees, replaced when the executive changes. The administration is not then seen as 'neutral' and does not necessarily have greater expertise than the executive.

Health departments usually have relatively low status within this ensemble of state agencies. Many politicians regard the health sector as peripheral and the sector often fails to attract political high-fliers unless there is a particular crisis. In the event of a clash of preferences with more prestigious or economically productive sections of the state, health department's preferences are likely to be over-ridden (Walt, 1994: 86). This low status has implications for its dealing with other departments whose policies affect health, yet who are reluctant to change them when to do so would compromise priority goals such as economic growth. Health departments are rarely entirely unified bodies. Often tensions exist between different sections of the health service, especially in low-income countries in which powerful, externally funded vertical programmes are seen as acting beyond the control of central health boards (Walt, 1994: 86).

Finally, the implementation of health policy is frequently the responsibility of district and provincial health boards. Decisions made at sub-national level about how to operationalise policies and how resources should be allocated will have a significant impact on policy development and overall resource distribution. Since the 1980s, many low-income countries have been attempting to decentralise their health services amidst strong pressure from the international community. Though the process of decentralisation takes different forms, central bodies usually retain control over planning and policy formulation, limiting local autonomy through mandatory demands, targets and budgetary allocations (Atkinson, 1999).

ii. Civil society organisations

Historically, International Relations theorists have paid relatively little attention to non-state actors in policy development. In a discipline that has been dominated by realists, it was assumed that they were relatively unimportant. They did not, ultimately, affect power relationships between countries and the state could close them down if they became incompatible with the 'national interest'. In the last twenty years, however, they have become an increasing focus of attention in national and international studies (see: Willetts, 1993). The end of the Cold War served to reinforce this trend, with 'civil society' being seen increasingly as an essential part of a stable, democratic system. In donor discourse, the term 'civil society' is used to describe relationships, social groupings and values that are not solely determined by family and kin ties, yet are not of the state (Gellner, 1994). It is seen as generating wealth and ideas in competition with the state and moderating the more pernicious aspects of authoritarian state control (Harbeson *et al*, 1994). To this end, donors are channelling increasing amounts of aid towards 'civil society', usually in the form of non-government organisations (Van Rooy, 1998).

How, though, are societal preferences organised and articulated in a political system? Broadly speaking, this influence can be analysed on two levels. The first way is to look at civil society organisations (CSOs) whose aims are specifically to influence policy. If the expression 'civil society' is viewed as a general 'associational realm' of heterogeneous interests and relationships, the term CSOs refers to organised, purposive non-state groups. Not all CSOs are interested in influencing policy, however, so I shall focus my discussion on pressure groups – those groups that have an explicitly political dimension to their activities, even if that is not the sole or even main reason for their existence. The second way of looking at the way societal preferences might influence policy is broader, and looks at dominant values within society and how the political system is maintained and reproduced. This is discussed in more detail in the section ii. below.

Pressure groups are those that explicitly seek to influence political decisions. The expression usually refers to non-state organisations, though Lindblom expands the definition to include factions within the state that seek to influence policy (cited in

Jordan and Richardson, 1987: 187). Pressure groups may be divided into two main groups: sectional groups and promotional groups (Willetts, 1982). Promotional groups seek to promote causes arising from a particular set of values, and fall into five main categories.

- Welfare agencies (NGOs). This expression refers to groups that run operational welfare programmes and/or raise funds to provide education, health or social services. Though welfare organisations do not necessarily have a lobbying role, advocacy is becoming an increasingly important part of NGO activities (Van Rooy, 1998: 36).
- Religious organisations are concerned with the general promotion of (religious) values. The extent to which religious organisations become formally involved with politics varies. They can, however be significant advocates on behalf of sections of the population or around certain core values. Most major religions have a formal trans-national structure and are involved in lobbying and advocacy in the international arena.
- Community groups. These arise when distinct segments of society such as people of a particular geographic area or ethnic origin organise to promote their group identity or status. Community groups may include woman's groups, who are involved in similar issues of group identity and status.
- Political parties. Opinions are divided as to whether political parties are analytically distinct from pressure groups as they seek to win office rather than influence policy outcomes. Willetts (1982) argues that they often function as pressure groups. Some political parties have no realistic chance of winning power, but are formed to promote particular issues. Political parties can also act as pressure groups on government even when 'the party' itself is in office. There is often a distinct difference between the views and interests of government, and that of 'the party' it purports to represent.
- Specific issue promotional groups. Promotional groups such as human rights organisations, gay groups and patient's organisations have had a considerable influence in the HIV/AIDS arena, as will be discussed in more detail in subsequent chapters.

The second category of pressure group is sectional groups, those that seek to protect the interests of particular sections of society. They fall into three main categories.

- Professional associations. Organisations that represent the health professions play a particularly important role in health issues generally and HIV/AIDS in particular. The health sector is unusual in the relatively high status accorded to its professional advisors, many of whom have a substantial influence on policy development (Ham, 1999). The predominance of medical professional values has led to a historical tendency to equate 'health' with medicine, rather than environmental factors, which may have a far greater impact on peoples' health (Ham, 1999: chapter seven). Health resources are often diverted to expensive drugs, hospitals and equipment, even when health plans cite primary health care as being the most urgent priority (Macrae *et al*, 1993). In Africa, many advisors are expatriates funded by donor organisations. This has led to criticism that their advice can be inappropriate for local conditions (Cliff, 1993). The activity of professional groups in Britain and Zambia will be discussed in more detail in chapters four and five.
- Sectional economic groups. These may include individual companies, as well as business or sectoral associations as well as trade unions. Business interests, articulated via direct lobbying from individual corporations and business associations have had a significant influence in various specialist areas of AIDS-related policy such as private insurance and drug development (see Berridge, 1996).
- Sectional recreational groups, for example sports associations and member-based leisure organisations.

The distinction between promotional groups and sectional groups is a useful first step towards categorising social organisations, however it says little about *how* groups influence policy. Grant (1995: 15) suggests that it is more helpful to categorise pressure groups according to the strategies they adopt when they seek to influence policy. Thus, pressure groups can be sub-divided into 'insiders', who work with policy makers and who are recognised by them as having a legitimate

claim to policy relevant knowledge, and those that choose or are compelled to remain 'outside' government policy circles. This basic distinction can be further refined to take into account the different resources available to pressure groups and state attitudes towards them. State actors may choose deliberately to exclude certain pressure groups from any form of consultation. Equally, particular groups may not have the technical capacity to lobby government effectively. Thus, pressure groups can be categorised in the following way:

- Prisoner groups. Groups that find it difficult to retain political independence from government because of their dependence on state funding.
- Low profile insider groups. Pressure groups that work quietly behind the scenes with government agencies.
- High profile insider groups. Groups that work closely with government but may sometimes choose to generate public support for their particular viewpoint.
- Potential insider groups. Those groups that have the potential to become insiders, but have yet to develop a particular interest and expertise in so doing.
- Outsider groups by necessity. Those groups that are deliberately excluded from the decision-making process, or that do not have the political, financial or technical resources to lobby government effectively.
- Ideological outsiders. Those groups that reject the existing political system and who have no interest in attempting to collaborate with representatives of regime they regard as illegitimate (Grant, 1995).

Interest in pressure group activity has increased dramatically since the end of the Cold War. There are, however, various critiques of this growing confidence in the non-government sector, and in civil society as the agents of democracy. Some writers argue that interest groups have a negative influence on policy, forcing minority interests on government to the detriment of the majority (Olson, 1982). Pressure group activity can reinforce patterns of political inequality. Businesses, for example, already have a significant influence on social and political organisation. Organised business lobbies may simply reinforce this influence (Grant, 1995). Another widespread criticism is that the concept has limited

applicability to the majority of low-income countries. Many Southern states do not have a strong tradition of well-organised, high profile non-government pressure groups (Walt, 1994).

Some writers have gone so far as to argue that 'civil society' is incompatible with a society in which relations are ordered through the traditional ties of family, caste and kin (Gellner, 1994). Such a formulation, however, over-estimates the extent to which 'modern' societies are freed from 'traditional' ties, which in fact coexist in (relative) harmony with professional and social associations (Etzioni, 1997). It also under-estimates the networks of formal and informal professional, trade and interest groups that exist in low-income countries (Chazan *et al*, 1992). Though civil society organisations in the Western sense have traditionally been weak in many low-income countries, there are other channels for external pressure. While ethnic identity *per se* is often poorly articulated, some ethnic, familial and kin groups are formally organised and provide a significant form of external pressure on state organisations (Scott, 1998). Non-government organisations, which were originally formed to provide relief for vulnerable communities, are taking an increasingly high profile role in advocacy on the national and international stage (Richmond and McGee, 1999). Donor funding has brought them significant resources and greater organisational capacity. In some cases, they are being brought directly into the policy-process though seminars and consultative committees.

ii. Societal pressures

Thus far, I have discussed the role of organised pressure groups. Political decisions can, however, be influenced by values and attitudes within society more generally. As I have already argued, widely held religious or cultural values will have an influence on which policy options are regarded as 'sensible' or politically feasible. Issues surrounding HIV/AIDS touch upon deeply-held religious and moral beliefs, which has had profound implications for policy development in the area, as I will discuss in more detail in chapters five and six.

How, then, can society influence policy? The answer to this question depends on the nature of the state and on the political system in operation. These have a profound impact on the way in which societal preferences are articulated. For Hirschman (1970), the three main channels of political expression are exit, voice and loyalty. Loyalty is an indicator of the extent to which citizens accord legitimacy to their government and even the identity of the nation-state itself. Voice is the process by which citizens express their dissatisfaction with government performance. The ways in which public 'voice' is articulated depends on the nature of the state. 'Voice' can range from voting or lobbying at party conferences to violent demonstrations and political coups. Civil disobedience, or even the perception of its threat, can exert influence on state policy makers (Day and Klein, 1989).

For Hirschman, exit is primarily an economic response. Citizens may seek recourse to the market for goods or services when the state is not adequately providing for them. For example, an individual may choose to pay for private medicine when they lose confidence in state health provision. The significance of 'exit' as a form of political pressure is of particular relevance to businesses. Government policy makers are mindful of the fact that businesses may move abroad if they do not develop policies that are perceived as acting in the general interests of capitalist endeavour. Thus, businesses have an indirect influence on policy development that is quite separate from the organised lobbying discussed above. This form of indirect influence has some relevance to the formation of HIV/AIDS policies. Chapter five will discuss how public health officials persuaded policy-makers of HIV/AIDS significance as a policy issue by estimating its potential impact on business profitability.

Recent developments in thinking on the dynamics of poverty and social exclusion suggest that rather than seeing exit solely as an economic response, it is helpful to see citizens' economic and social responses as interdependent (Rodgers *et al*, 1995). Citizens who choose, or are indeed forced to 'exit' from state services, are often socially and politically excluded as well as economically. Equally, the ability to exercise 'voice' effectively is often intimately related to economic power and the

availability of exit options (see Lindblom, 1979). This debate is of particular relevance in developing countries, where health services are often effectively outside the geographic or financial reach of many poor households. In Africa, many people use traditional healers in the first instance of ill health, using formal state-sponsored medical services only as a last resort. The fact that traditional healers are not included within national health strategies reflects the way health ministries were formed and the articulation of interests at state level, as will be discussed in more detail in chapter four.

Summary

In this chapter, I have outlined a theoretical framework within which to understand the Global AIDS Strategy's impact. Rather than being a process of applying technical solutions to objective problems, each phase of the policy process is inherently political. Not all the agencies within this political process, however, have equal influence. For historical reasons, some agencies are in a position to influence the environment within which decisions are made, thereby affecting the capacities of other groups. I have argued that the capacities of and relationships between groups vary over time. In some circumstances, groups increase their cumulative influence over policy outcomes by working with, rather than in conflict with other groups. These networks, which are dependent on each other for resources, can act together to exclude other groups from key stages in the policy process. In the final section, I mapped the main types of group that are likely to be involved in implementing the strategy in any particular country and gave a brief overview of the constraints and opportunities for them to influence policy development.

In the following chapter, I will discuss the methodological framework that underpinned my research. I will then go on to discuss the policy environments in the two case countries, which have been chosen from the 'developed' and 'developing' world. Network theory has not yet been extended to developing countries and I will therefore conduct a review of the literature on developing country policy environments more generally. Subsequent chapters will explore

how far network theory can be usefully applied to these very different policy environments, and how it can help to conceptualise trans-national policy influences.

Chapter three: Research methodology

Introduction

In the first chapter I outlined three major research objectives: to establish the extent to which the objectives of the Global AIDS Strategy were achieved, to identify the ways in which the WHO/GPA's Global AIDS Strategy impacted upon the development of national AIDS policies and to explore the main factors that account for any observed impact. In other words, I seek to identify an effect and to establish a causal link: between the Global AIDS Strategy and policy developments. In the second chapter, I reviewed the literature on trans-national policy influences and argued that the influence of one particular group can only be understood within the context of the resources and organisation of other groups. It follows, therefore, that any observed impact has to be viewed within a complex environment of existing policies, organisations and political and economic trends.

In this chapter, I will demonstrate that a case study approach using both quantitative and qualitative techniques is the most appropriate way to explore this complex environment and to establish how the strategy's implementation influenced and was in turn influenced by the policy environment within which it operated. In this thesis I use case-studies in Britain and Zambia to explore the processes by which the Global AIDS Strategy influenced the development of AIDS policies, focusing on how differences in a country's relative wealth affected the Strategy's impact. I will then give a more detailed account of the research methods I used and the ways in which I minimised the potential pitfalls of the case study approach.

1. Research methodology

There are many ways of conducting social research and the choice of research methods is determined by the questions being posed. This thesis explores a complex causal process, looking at how a range of organisations negotiated and implemented a global undertaking. In the following section, I will argue that a purely quantitative approach to these questions would be an inadequate way of

explaining the various impacts of the Global AIDS Strategy. Exploring case-studies in detail using a combination of quantitative and qualitative research methods was the most effective way of tackling these questions given the resources that were available.

A. The quantitative approach to measuring policy interventions

One approach to determining the effect of policies is to establish indices to measure the scale and distribution of a problem. The UNDP, for example, has established a set of indices to measure levels of 'human development'. The level of education is measured by looking at school enrolments and literacy rates; health by mortality rates and so on. Comparisons can then be made between levels of 'human development' in different countries and development interventions' impact can be monitored by comparing how these indices vary over time.

One way of measuring the effect of the Global AIDS Strategy would then, be to look at a cross-section of the signatory states and use indices to establish how AIDS funding changed, whether governments set up AIDS programmes and how HIV transmission patterns varied over time. There are, however, various problems with this approach. Firstly, they could neither establish nor explain a causal relationship between the Strategy and policy development. Secondly, there are glaring inadequacies in the quantitative data available and thirdly, the approach would fail to compare like with like.

i. The causal relationship

This research seeks to examine a causal process, the ways in which various organisations impacted upon each other. Sample data might establish a correlation between variables, but could neither establish nor explain a causal relationship between them (Stake, 1994). The endorsement of the Global AIDS Strategy, for example, coincided with an increase in funding for HIV/AIDS interventions. It does not necessarily follow, however, that the signing of the strategy caused this increase. Indeed, the causality might be in the opposite direction: the strategy was endorsed because policy-makers were *already* concerned about AIDS, as

evidenced by their commitment of extra funding. It is necessary to conduct further research to establish the relationship between the two variables. Equally, quantitative indices of financial and organisational resources provide only a partial picture of as complex and multi-faceted a process as 'political influence'. As I have already argued, one group's impact is as much defined by historical precedent and their relationship with other groups as on their financial resources.

ii. The nature of the data

A study that looks at cross-sections of a given population would also be seriously compromised by the nature of the data that was available to me. Given the resources that were available to me to conduct this research, acquiring primary data on a statistically significant sample of the signatory states was impractical. I would have to rely on data that had already been produced by various government and international agencies. This data is, however, flawed in various significant ways that would limit the inferences that could be drawn from such a survey. The three main objectives of the Global AIDS Strategy were to reduce the spread of infection, to reduce the social and personal impact of HIV/AIDS infection and to co-ordinate national and international interventions. The three clearest indicators of how far these objectives were achieved are a) changes in transmission rates b) the presence or introduction of discriminatory or anti-discriminatory legislation and c) changes in funding flows for HIV/AIDS interventions.

Data on each of these have been collected by the WHO on a trans-national basis and used as general measures of government commitment and the efficacy of interventions. Used in isolation, however, these indicators give an inadequate picture. Firstly, estimates of the levels of infection with the HIV virus are unreliable. There is a time span between infection and producing HIV anti-bodies that are identifiable for testing purposes. There is a further, indeterminate gap between infection and showing the symptoms of AIDS. Testing procedures are often patchy and inadequate with many countries unable to afford adequate testing programmes. Many people are unwilling or unable to be tested and a significant number of AIDS deaths go undiagnosed. Political and cultural factors can have a

significant impact on reporting rates. Without state commitment to testing programmes, empirical evidence about HIV prevalence will simply not be produced. Low-recorded rates of infection may therefore mean nothing more than that the government has not been looking for the problem.

Similarly, though the WHO has produced international data on HIV/AIDS legislation, it would be unsafe to assume that the presence of anti-discriminatory legislation is necessarily evidence of a committed policy of non-discrimination and government support to people with HIV/AIDS. Conversely, a state may have legislation that appears to discriminate against people with AIDS but, for a number of reasons, may fail to invoke it. The relationship between public policy and state legislation is complex and highly dependent on the legislative traditions of the particular state.

Thirdly, it is notoriously hard to obtain reliable information about HIV/AIDS funding. In part, the problem is practical, as the information to be collated involves so many different countries and organisations, each with its own accounting methods. Funding for AIDS prevention or care is often donated as part of wider-ranging development projects, and it is not always possible to identify AIDS spending as distinct and separate (Laws, 1996). These practical obstacles to collecting reliable data on funding and prevalency are compounded by another difficulty, which strikes at the heart of the problem of using data from one particular group or set of groups. The government and international agencies that provide the main sources of quantitative data on HIV/AIDS have their own agendas, which affect the form and extent to which they publish information. Official publications say as much about the organisations that produce them as the problems they report (May, 1993). Ultimately dependent on external goodwill and support, agencies use official publications to 'sell' their organisation and programmes. The amount donors claim to have given to developing countries, for example, is often larger than donees say they have received (Laws, 1996). Administrative costs, for example, may be deducted from the overall contribution. At the same time, the amount recipient governments acknowledge they have received from donors may not reflect the sum that is actually spent on aid

programmes. The 'Good Governance Agenda' introduced by the World Bank and since taken up by most of the main donor organisations was designed specifically to combat what is suspected to be significant corruption within development projects (Mosley, Harrigan and Toye, 1995).

iii. The diverse population

Notwithstanding the problems of data on HIV/AIDS interventions, a cross-sectional analysis of input/outputs in terms of HIV/AIDS policies would offer a weak basis for comparison. The population of signatories to the Global AIDS Strategy encompassed such a huge range of political, economic religious and cultural systems that drawing inferences from an international sample would be of dubious value. How much funding, for example, would represent evidence of the UK government's commitment to a problem? How could you compare this contribution with that of a small, low-income country? Different countries also came from different starting points in terms of their attitudes to sexuality and sexually transmitted diseases. It would not be possible to draw any inferences about the extent of that influence from simple outputs such as changes in legislation or funding unless they are followed up by a more detailed examination of particular political and socio-economic contexts. The WHO may have exerted very substantial influence to achieve a relatively small concession in deeply embedded policies of discrimination against people with sexually transmitted diseases. Finally, HIV/AIDS did not affect all countries equally, so it would be unrealistic to expect some international 'norm' in terms of policy interventions. Only by looking at a particular case would it be possible to draw conclusions about the nature and extent of the WHO/GPA's influence.

B. The case study approach

Case studies are one of several ways of conducting social research. Unlike experimental methods or surveys, case studies do not make claims to representativeness, they focus on a particular case and examine it in detail. The case studies in this thesis use both quantitative and qualitative techniques to

describe how the WHO/GPA's Global AIDS Strategy impacted upon a range of organisations. The aim of this research is both contextual and diagnostic. Its first aim is to identify the form and nature of the relationships between the various organisations involved in AIDS policy making. Then, information from a number of different sources has been used to establish the main factors determining what exists (Ritchie and Spencer, 1994).

As a research strategy, however, case studies are often criticised for being unscientific. Evidence obtained from case studies, it is argued, is often subjective (Yin, 1994). No two researchers would approach the research site in the same way and could interpret information very differently, depending on their individual interests and experience. Equally, it is argued, the results from individual case studies are ungeneralisable, and thus of little value in generating theory. The response to these criticisms has been mixed. Some writers question the relevance of a 'scientific' approach to the social sciences, arguing that events in the social world are too complex for an approach which depends on examining the effects of single variables in a controlled environment. Stake (1994), for example, argues that while case studies may be subjective, that does not necessarily undermine their validity as long as the researcher is careful and reflective. They are simply a different way of constructing knowledge. Indeed, by foregrounding the researcher's interpretations, they can help avoid the situation in which implicit biases are hidden behind the veneer of scientific objectivity. The design of *any* research project will necessarily be informed by theoretical and cultural 'baggage' on the part of the researcher.

That said, steps can be taken to make case studies as reliable as possible. Yin (1994) argues that case study methodologies can and should be designed in a way that fulfils 'scientific' criteria of reliability. Because a research design is supposed to represent a logical set of statements, it should be possible to judge the quality of any given design according to *logical* tests. Thus, the four tests common to all social science methods — construct validity, internal and external validity and reliability — are equally relevant to a case study approach. The methodology has been designed with these tests in mind.

i. Construct validity

One of the most common complaints about case study research is that it fails to establish sound operational measures for the concepts being studied (Yin, 1994). In the absence of a proper definition of the phenomena that are being observed, the case study becomes a subjective interpretation of events. Yin argues that two criteria have to be met in order to satisfy the test of construct validity. Firstly, the specific types of changes that are to be studied must be properly identified. Secondly, the researcher must demonstrate that the selected measures of these changes reflect the specific types of change that have been identified. In my particular research, it is important to define what 'compliance' with the Global AIDS Strategy means in operational terms and to develop appropriate measures.

As a first stage in this process, I have summarised the Global AIDS Strategy, as shown on page four. Viewed schematically, it is possible to identify the composite elements of the strategy. The Global AIDS Strategy was based upon two major premises that had direct policy implications for signatory states. The first was that AIDS was a serious problem that should have political, technical and financial resources directed towards solving it. The second was that it should be done within a non-discriminatory legal framework. Both of these have measurable outputs. If the Global AIDS Strategy was implemented successfully, we could expect the financial and technical resources devoted to HIV/AIDS to increase after the strategy was signed, and the legal framework altered accordingly. On an organisational level, we could expect to see the establishment of a centralised government agency to deal with the problem of HIV and AIDS, and NGOs should be actively involved in implementing WHO/GPA operational policies.

The strategy also had three major objectives: to prevent HIV infection, reduce the personal and social impacts of HIV infection and to unify national and international efforts. Had the strategy been successful, we would expect to see a decline in rates of infection, welfare services for people with HIV/AIDS and an integrated national response in alignment with the WHO strategy. Though precise figures for the rate

of infection are difficult to obtain for the reasons I discussed above, it is possible to discern broad trends in rates of transmission from epidemiological reports. Similarly, surveys provide quantitative evidence about changes in the populations' knowledge and attitudes towards HIV/AIDS and changes in their sexual behaviour. It is possible to discern the extent of HIV/AIDS interventions by looking at changes in funding patterns and organisational responses. The extent to which countries sought complied with the strategy's undertaking to avoid discriminatory legal practices can be partially gauged by the presence or otherwise of legislation that either discriminates against people with HIV/AIDS or prohibits discrimination. The WHO compiled tabular information on the legal instruments dealing with HIV infection and AIDS in all its member states (WHO, 1994b).

While these quantitative indices create some structure to a complex and unwieldy subject matter, on their own they can not establish a causal relationship between the WHO/GPA's Global AIDS Strategy and changes in the scale or impact of interventions. As Walt *et al* (1999a) have noted, it is extremely difficult to gauge the effectiveness or impact of aid co-ordination. Thus, further interpretative research is needed to try to identify ways in which the GPA's 'Global Programme' influenced policy development and the main constraints to its impact. I therefore supplemented this quantitative data with evidence from articles, reports, policy documents and 'grey literature'; in-house publications from relevant organisations. Finally and perhaps most importantly, I undertook a series of in-depth, semi-structured interviews with key members of the AIDS policy network.

The interviews served to put the quantitative data into a local context that could then support comparison between the two countries. Differences in resource availability and health status in the two countries make it difficult to make direct comparisons between funding levels or sero-prevalency. The interviews were used to explore how senior, experienced AIDS personnel perceived the scale and efficacy of the response to AIDS given the resources that were available and the scale of the problem in that particular context. It was then possible to identify areas where the response had been relatively weak and establish why problems had occurred or how the WHO/GPA may have impacted upon policy development.

The table below defines the intended 'outputs' of the strategy, the quantitative indices I have used to measure changes over time and the sources of qualitative data I drew upon.

Table 3.1. Global AIDS Strategy output indices and research resources

Overall objectives	**Quantitative data**	**Qualitative**
1. Prevention of HIV	Sero-prevalency data Knowledge, Attitude and Practice (KAP) Surveys	Interviews Reports/articles
2. Alleviating personal and soc. impact.	Organisational responses NAP established Legislation enacted	Interviews Articles Annual reports/ policy documents
3. Mobilise and unify nat. and int. efforts	Funding data. Admin structures	Interviews Annual reports/ policy documents

ii. Internal Validity

The test of internal validity has its origins in the causation experiments of the natural sciences, the logic being that the most common threat to an experiment's validity is that of 'false' results caused by unaccounted factors. One of the fundamental premises of my research is that policy decisions are informed by a range of socio-economic, cultural and political influences. It is therefore inappropriate and misleading to attempt to identify and measure the effects of a single determinant of social change mathematically. That said, it is still possible to explore the main ways in which a particular organisation influences others. This

research explores the relationship between an effect — national AIDS policies that correspond with the WHO's Global AIDS Strategy — and a causal process — the influence of the Global AIDS Strategy. For that reason, the *logic* of the internal validity test has relevance to my research design. In individual case studies, the challenge of checking that a particular inference is correct can only really be tackled by triangulation, defined as a "process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation" (Stake, 1994: 241). By using secondary sources to establish whether changes took place, in combination with interviews from the representatives of a broad range of interest groups, it should be possible to ensure that the conclusions drawn are appropriate and accurate.

iii. External Validity

Another criticism of case study research is that it is impossible to generalise from a particular case. Research findings are thus of little relevance to an implied hard core of social 'science'. Many factors could influence the way in which the strategy was implemented in a particular state, so can a case study be anything more than an intrinsically interesting history?

Firstly, case studies can be a useful way of examining the *process* of influence in a way that an input/output analysis of whole populations can not. Experimentation approaches to understanding these relationships are acknowledged to be problematic as statistical correlations do not actually establish any type of causal association (Yee, 1996). Secondly, I follow Yin's argument that complaints about generalising from case studies are based upon the unsuitable application of representative logic to a very different line of research enquiry (1993). Case studies are not 'representative' in the sense of carefully chosen statistical samples. They can, however, fulfil the criteria of being *analytically* generalisable. Used cumulatively, case studies can test and revise theoretical propositions (Eckstein, 1966). Treated in this way, case studies can be a relevant and productive addition to the international policy debate.

iv. Reliability

Case studies have also been criticised for subjectivity. Were another researcher to conduct the same research, they might come to different conclusions *via* a different route. In comparison with quantitative research, the actual process of qualitative research, particularly data analysis, is often opaque to outsiders (Ritchie and Spencer, 1994). To some extent this is unavoidable when analysing something as abstract and complex as social policy (Stake, 1994). Any analysis is bound to be selective in the way it is presented and argued. However, I have minimised this risk by making my research criteria explicit and keeping a record of all sources. Interviews have been conducted and analysed systematically. These procedures are discussed in more detail later.

C. Choosing the case sites

Having argued that the case study method is the most appropriate way of examining the research questions, I will now turn to the question of deciding which cases to investigate. The priority of this research was to compare the relationship between the WHO/GPA and a high- and low-income country. The most significant divide between the WHO's member states is the distinction between the low-income net recipients of WHO financial and technical support, and the industrialised countries upon whose contributions the organisation ultimately depends. The WHO is a member-based organisation and members' contribution to its general funds are based on their GDP. The organisation is also becoming more dependent on extra-budgetary funding from industrialised countries to fund health interventions in low-income states (Walt, 1993).

The Global AIDS Strategy provides a means of exploring how differences in state income impact upon the relationship between states and international agencies and how this in turn impacts upon policy. There are significantly divergent opinions in the international relations literature about how national income affects the extent to which states comply with international agreements. The Global AIDS Strategy provides a relatively discrete case study of the effects of an international organisation over a defined period. It allows consideration of how international

organisations influence the way that policies are put on to the international agenda and how they influence the way countries develop policies.

Explicit comparisons between policy interventions in high- and low-income countries are rare in the policy literature (for an exception to this general rule, see Collins, Green and Hunter, 1999). Though interventions in low-income countries are often measured against a Western template, the comparisons are implicit. Explicitly comparative research is usually conducted on a North-North, South-South basis. This is partly because of the historic disciplinary divide between the Social Policy literature, which has tended to focus on welfare provision in industrialised countries, and the Development Studies literature, which focuses on the analysis of interventions in low-income countries. It is, however, increasingly recognised that the study of social policy needs to take a more international perspective (Lewis, 1998; Deacon *et al*, 1997). Supra-national 'public' organisations such as the IMF, World Bank and WHO, and supra-national NGOs have key roles in policy formation and implementation and their influence needs to be understood. Deacon *et al* (1997) argue that Social Policy analysts could usefully draw upon work on developing countries in order to make sense of these developments.

There are, however, significant methodological implications in drawing North/South comparisons. The Comparative Social Policy literature is largely based upon detailed comparisons of welfare interventions in industrialised countries. Predicated on a quasi-scientific experimental approach to understanding causation, Comparative Social Policy is based on the assumption that states and societies are not wholely unique, but that central elements exist that are common to all countries (Hauser; 1993). These common cores may be smaller or greater, but there always remains a domain of unique features which makes complete comparison impossible. It follows that the most 'complete' comparisons can be made between countries that are as similar as possible. Only then can analyses focus specifically on identifying the factors that cause different policy results. Within this logic, drawing comparisons between interventions between countries of

very different social, political and economic backgrounds would make comparison difficult if not impossible.

This thesis, however, focuses on one dynamic: the relationship between the WHO/GPA's Global AIDS Strategy and policy development. I am not comparing British and Zambian responses to HIV/AIDS *per se*. To do so would immediately raise the problems of comparability. The epidemics in Britain and Zambia took different routes and the organisational, economic and political environments were very different. In a comparison of the relationship *between* international and national policy networks, however, exploration of these contextual differences become an important way of *explaining* differences in impact.

The Global AIDS Strategy was an explicit attempt to homogenise policies across the range of signatory states encompassing every sort of political system and level of GDP. As an explicitly 'global' strategy it is justifiable to examine its impact upon very different countries. To do so is useful in that it allows examination of the whole system, rather than one aspect of it. Most evaluations of the GPA's interventions have focused on programmes in developing countries. In so doing, they fail to look at donors' expectations and how political negotiations between donor organisations and international agencies impact upon the development of policy interventions. The comparison also provides a means of exploring the implicit assumptions that are hidden behind 'global' resolutions. The strategy was signed by every member state, yet reason tells us that the relationship between a state and an international agency will differ depending on the direction of resource dependency.

Having decided to compare one high- and one low-income country, I then come to the choice of particular case sites. The two countries I have chosen to compare are Britain and Zambia. I chose Britain for a number of reasons. In the first place, it was a convenient place to start. I was familiar with the policy environment and assured of easy access to information and key policy-actors. There is little to be learned from a hostile case (Stake, 1994). Britain is also thought to have a historically good relationship with the UN and its agencies (Krause, 1995). Taken

together, it seems to be a good opportunity of examining the relationship between a government and an international organisation in auspicious circumstances.

I chose Zambia because it is a fairly typical low-income, heavily indebted state. Though the two countries are very different, it has certain similarities with Britain that reduced the number of dependent variables and allowed me to focus on the donor/donee relationship between the WHO/GPA and the case countries. Its political and administrative systems bear a close resemblance to that of the UK, its former colonial government. Its state institutions and the majority of its population are officially Christian, which has implications for attitudes towards controlling a sexually transmittable disease. Both countries have a historically close relationship with the WHO (Walt, 1993). The following chapter discusses the policy environments in the two countries in more detail. On a practical level, I had numerous contacts in Zambia and the University of Bath has close research links with various agencies there. The official language is English and I was confident that I would have good access to a variety of contacts.

2. Research methods

Having explored the over-arching methodology of this research, I now turn to a more detailed discussion of the particular research methods I employed. The research was divided into two broad areas. The first was an analysis of secondary data from government, international organisations, NGOs and academic journals. Information about state policies from government or the WHO was interpreted in the light of the growing body of critical literature from NGOs and pressure groups. The second stage of my research was a series of in-depth interviews with senior members of the policy network.

A. Secondary data

In the first stage of the research I looked at published data from a variety of agencies that were involved with planning, implementing or monitoring HIV/AIDS interventions. This stage of the research had two aims. The first was to gather together empirical data on AIDS funding, changes in sero-prevalency and

organisational responses to HIV/AIDS as a means of quantifying the 'outputs' of the strategy I have already identified. The second objective was to collect data that might repudiate or confirm observations made by the interviewees.

B. Interviews

The second stage of the research was a series of in-depth interviews with key members of the AIDS policy community. Interviews were semi-structured and lasted approximately one hour each. There were five main areas I wished to explore, but I allowed each respondent to develop their own ideas and asked subsidiary questions where clarification was needed. The interviews had two main purposes. The most important objective was to establish how senior role-holders explained the influence, or not, of the Global AIDS Strategy. The second was to provide confirmation of the findings of my initial documentary research. The case country may or may not have had non-discriminatory legislation, for example, but did respondents feel that it had achieved a non-discriminatory environment within which to work?

i. The interview schedule

When designing the interview schedule I bore in mind that I would be approaching people from a range of organisations who would be looking at HIV/AIDS policies from very different perspectives, cultures, educational backgrounds and experience. The questions I asked should be 'open' enough to be productive prompts for discussion, yet structured enough to allow meaningful comparison between interviews. I encouraged general discussion first, but then give more specific prompts to clarify what I meant to the respondent and to ensure that answers were sufficiently focused.

I was also aware that interviewees' involvement with and commitment to the objectives of the Global AIDS Strategy would vary. I therefore asked questions which would invite discussion even if, for example, people had never heard of the

Global AIDS Strategy, or had been quite unaffected by it. In these circumstances, I wanted to be able to explore the reasons why that may have been the case.

Interviewees can be confused by questions or, inadvertently and quite understandably, answer them selectively (Bulmer, 1993). I therefore ensured that questions 'over-lapped' and that issues that were raised by one question were also raised in another, albeit from a slightly different direction. In so doing, I created a means of cross-checking to see whether responses were consistent with each other, that the respondent understood what I was trying to ask and that they had discussed the issue as fully as possible (see appendix 1).

ii. Interview Samples

The sample of interviewees was dictated by the organisational design of the Global AIDS Strategy. I identified the main organisations that were identified in the Strategy as being necessary to its successful implementation. I then interviewed senior representatives of prominent NGOs. NGOs were an important source of information for two reasons. Firstly, resolution WHA42.34 included an undertaking by states to seek ways of "developing effective working relations with non-governmental organisations and strengthening their capacity to respond to AIDS within the framework of the Global AIDS Strategy" (WHO, 1989c: 1). By talking to NGO representatives, it would be possible to establish the ways in which they were involved with government and thus gauge the extent to which the strategy was implemented in that particular respect. In the second place, whether or not they were directly involved in this way, they could provide an alternative view of the AIDS problem and the adequacy of policy responses to it. They could also suggest reasons why policies may or may not have achieved the objectives of the Global AIDS Strategy.

I then identified experienced, executive-level staff within these organisations and wrote to them requesting an interview. I obtained individual names from a number of sources including reports and conference minutes. I wanted to speak to people with a wide experience of AIDS, who were working in the field at the time the

Global AIDS Strategy was first endorsed. Having interviewed this group, the 'snowball sampling' question picked up any organisations or interest groups which were influential in a way not foreseen within the design of the Global AIDS Strategy.

In Britain, I conducted 20 such interviews. As I will discuss later, the impact of the WHO/GPA Global AIDS Strategy was confined to a relatively small number of senior executives and the snow-ball sampling questions established quite a clearly defined group who had worked with the WHO/GPA. That and the fact that there exists a rich supply of data on meetings, conferences and organisational responses meant that it did not prove necessary to expand the original pool of interviewees very greatly. AIDS organisations in Zambia had far closer and more integrated relationships with the WHO/GPA and it proved necessary to conduct more interviews. I conducted 67 separate site visits and interviews over a five-month period. The majority of my research took place in Lusaka, where government, the bi- and multi-lateral agencies and most of the main NGOs are based. I also visited and conducted interviews in Mazabuka district in Southern Province, the Copperbelt and Serenje in Central Province.

iii. The fieldwork

Most of the UK interviews were undertaken during the first year of my PhD in early 1997. I was fortunate in that most of the key people who developed HIV/AIDS policy in Britain were still working in the field. Even in the three years since then, some have moved on or retired. More than that, they obviously regarded the period as important personally and historically. They were therefore willing to help not just with the interviews but referring me on to people they thought it was important to interview. It quickly became clear quite how small the initial issue network was. The same names appeared time and time again in the 'snowball sampling'. Most knew each other well, having been regularly attending conferences and meetings together.

The closeness of the network, as well as the justifiable pride with which interviewees regarded their achievements in putting AIDS on the policy agenda

sometimes raised the question whether their responses were tinged by an element of *post hoc* justification. It was, however usually possible to confirm claims through reference to reports and minutes. Where it was not possible for any reason, I have reported comments as people's individual views. As I shall go on to discuss in greater detail, the collection and dissemination of information was regarded as one of the most important aspects of tackling the emerging problem. Advances in research or in organisational responses to HIV/AIDS were quickly published. Much of this secondary data was collected at specialist libraries such as the Kings Fund library in London and the Terrence Higgins Trust resource centre — which has a comprehensive collection of HIV/AIDS related literature.

The Zambian fieldwork took place in 1998 and received funding from the Department for International Development. Though the actual interviews and data collection could have been condensed into a far shorter time, I found that it took at least the first three months to begin to develop a rounded picture of the political and social dynamics in Zambia. As it was, it took time just to acclimatise myself socially and culturally. In Britain, for example, one can ask a fairly direct question 'politely' simply by changing one's intonation. The question 'Have you got time?' can seem polite or rude depending on the way the different words are intoned. Zambians have more formal etiquettes surrounding good mannered conversation and it is easy to seem brusque.

More than I had expected, I found that an important aspect of my research was simply spending time with people who were involved in making and implementing policy in various different ways. The first three weeks were spent staying with a World Bank economics adviser who was part of a close-knit group of expatriates, who were all working for different bilateral and international agencies. Generally speaking, morale was low in the expatriate community. Many expatriates were on short contracts and were concerned about their future. Aid contracts tend to be well remunerated, both financially and in living conditions. Financially, few people could find work in their home countries that was as interesting or gave them as much responsibility. However, the work — and lifestyle — has significant drawbacks. Clearly, expatriate life can put a strain on personal relationships.

People also felt that the brevity of their contracts under-mined their effectiveness. Often contracts came to an end just as people had begun to settle in and were making some professional headway with the project they had been employed to oversee. More than anything else, these expatriates felt bitter about the 'politics' of their work. They felt that they were constantly battling against bureaucracy and inter-governmental animosities, which frustrations will be discussed in greater detail in chapter six.

As a new arrival in a small expatriate community, I was frequently drawn aside so that people could explain to me how difficult things were for them, socially as well as professionally. There was a particular anxiety about safety, and most of the expatriates I met lived in secure compounds with armed security guards. Two people went so far as to warn me never to stop at traffic lights whilst driving a vehicle. To do so would only give thieves the opportunity of stealing its contents. Travelling alone and without a car, I was considered to be a prime target for crime, though in the event, I never experienced any problems. I deliberately chose not to rent a car. Travelling by foot, bicycle and public transport gave me more opportunity for observation. I was also loath to appear as though my research was supported by a donor agency and that co-operation with me might lead to some future financial reward.

The first three weeks were a useful introduction to the expatriate community, and I was able to learn a lot about the social and professional dynamics of expatriate life. After that, I thought it would be useful to move to a less exclusive area, where I met a broader cross section of people. I rented a flat in a block for hospital staff. I was therefore in fairly close and regular contact with a range of doctors. These forms of participant observation were extremely useful when I came to analyse data, enabling me to place people's responses in a broader context.

In general, the interviews went well. People were generous with their time and I was able to interview most of the people I wanted to. The questions generated useful responses and did not have to be modified. Language was not a problem, as all the people I needed to interview — senior representatives of AIDS-related

organisations — spoke good English. In general, however, people in Zambia were more cautious in their interviews than they had been in Britain. Several people refused to be taped, for example. One person only agreed to give a taped interview only after I had given my assurance that I would delete the tape as soon as I had extracted the necessary information from it and that I kept their comments anonymous. They feared serious repercussions should the government ever found out what s/he had said about them. A failed coup shortly before I arrived had prompted the government to declare a state of emergency. Some senior politicians had left the country and the former President Kenneth Kaunda had been placed under house arrest. Though the coup was not considered very serious, the incident made for a somewhat tense atmosphere. Given the strength of respondent's anxiety about confidentiality, and the fact that the AIDS issue network is relatively small, identifying individuals is relatively easy. I have therefore kept all the interviewees from Zambian civil society organisations anonymous, even those who were happy to have their observations attributed to them. Though this level of anonymity is in a sense unfortunate, allowing greater possibility for exaggeration or inaccuracy, interviewing senior participants is the only effective way of gaining the information I wanted. I therefore minimised the risk of being misled by only used information that has been verified from at least one other source.

The final problem with fieldwork in Zambia is that there are fewer sources of independent information on HIV/AIDS interventions. Most of the literature on interventions is produced or funded by the agencies that conducted the programmes. In the case of the WHO/GPA, these reports are written with the implicit goal of persuading donors and state officials of the significance of the problem and the value of on-going interventions, a phenomenon which will be discussed in more detail in chapter six. I did not find any literature that was prepared by independent, indigenous groups such as community groups or Zambia's AIDS patients' organisation. This absence made the interviews a particularly new and useful source of research material.

iv. Analysis

While I was analysing these interviews, I kept the criticisms of case study research in general and qualitative research in particular at the forefront of my mind. Generally, these approaches are criticised for being subjective and selective. I therefore made each stage of the analysis process as open as possible. I have kept full records of each stage of analysis in a research database. I was particularly concerned about the problem of subjectivity. Rather than simply reading and interpreting people's interviews, I used a systematic method of analysis. 'Horizontal and vertical read' is designed to ensure that every theme, explanation and empirical observation made by interviewers is recorded, and can be presented in a manageable way that allows comparisons between interviewees[1]. Such a method adopts a similar approach to Ritchie and Spencer's (1994) 'Framework' approach to the analysis of quantitative data. Essentially, data analysis is conducted in five key stages; familiarization; theme identification; indexing; charting and mapping; and interpretation.

Whenever possible I taped interviews. In certain circumstances, however, either interviewees were unhappy about their interviews being taped or the location was inappropriate. All tapes were transcribed *verbatim*, a process that proved extremely useful. The first phase of systematic analysis of qualitative data is familiarization (Ritchie and Spencer, 1994). The process of transcription made me considerably more familiar with each respondent's account and helped to ensure that I did not listen selectively, noting only those points that fitted in with some, perhaps unconscious, preconception. It also meant that everything the interviewer said became a matter of accessible and verifiable record, with the exception of those remarks that the interviewee had specifically requested to be kept off record.

I made an initial reading of the text, noting factual observations that confirmed or undermined information I had gathered from secondary sources about the extent to which the case country had conformed to the Global AIDS Strategy. I then turned

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[1] Professor Helen Haste, University of Bath Department of Psychology: personal communication.

to the question of how the Global AIDS Strategy had influenced the policy-process in the case countries.

Table 3.2: Horizontal and vertical read

Question/Response	*Int'ee A*	*Int'ee B*	*Int'ee C*
1. What effect did the G.A.S have on your organisation?			
"We attended their meetings and conferences"	1	1	1
"They funded us for small projects abroad"			1

I created a spreadsheet in Microsoft Excel and wrote the questions down the left-hand column. I then took the first interview and wrote down the interviewee's answers and observations below each question, with a '1' beside it in a labelled column, to indicate which interviewee had made the observation. I then repeated the process for the second respondent, creating a new answer if necessary or, if they repeated a point made by an earlier respondent, simply marking that they had repeated the observation.

When I had completed this process for each of the respondents I rearranged the various answers into sub-headed themes, though retaining the original quotations beneath the sub-heads for ease of reference. This created a single spreadsheet in which an individual respondents answers could be analysed longitudinally – comparing responses to different questions, and latitudinally – comparing answers from one respondent, or group of respondents with others. This provided a thematic framework within which data could be examined and referenced. The left-hand column provided an index of responses for subsequent retrieval and exploration. The process of identifying the themes that emerge from a particular body of data necessarily has an element of subjectivity. This system of annotating

textual data made it possible to ensure that particular interpretations could be substantiated by empirical evidence.

Summary

In this chapter I have argued that a case-study approach that combines both qualitative and quantitative data is the most appropriate way of answering the research questions and described the research methods I applied to the case countries. In the following chapter, I will discuss and compare the policy environments in the two case countries.

Chapter four: The policy environments in Britain and Zambia

Introduction

In chapter two, I argued that it is essential to understand the political and economic context within which the WHO/GPA's Global AIDS Strategy had to operate if we are to identify and explain any impact it might have had on the development of national policies. In this chapter, I will discuss the policy environments in Britain and Zambia at the time the strategy became operational. The first section reviews the literature on policy networks in Britain, focusing particularly on the health sector.

In the second section, I will discuss the policy environment in developing countries generally and Zambia in particular. Network theory has not yet been extended to the developing country policy environment and one of the intentions of this research is to explore the extent to which it provides a useful tool for analysing the asymmetrical relationships between donor organisations and lower-income states. There is always a danger in exporting analytical frameworks that have been developed in the West to analyse quite different societies. The resulting analysis can be inappropriate and misrepresent the complexity of particular societies (Chambers, 1998). Network theory, however, adopts an explicitly contextual, path dependent approach that makes it a suitable analytical framework to explore and compare different policy environments. Section two starts with a discussion of developing country environments generally with particular emphasis on sub-Saharan Africa, before focusing on Zambia in particular. I have adopted this approach for two reasons. In the first place, there is a relative paucity of literature on Zambian politics and policy compared with Britain. It is therefore useful to gain insights on its policy environment from analyses of similar countries. In the second place, it is useful to understand the wider context of Zambia's economic and political development. Though this thesis is focusing on specific case studies, I will

use this evidence to revise theoretical hypotheses about developing country policy environments more generally.

The table below puts a comparison of Britain and Zambia into broad perspective. Figures are taken as near to 1987 as possible, that being the year the Global AIDS Strategy was first endorsed. The two countries are at opposite ends of the spectrum in terms of both socio-economics and health status. Such differences were clearly likely to impact upon the expectations and functioning of their relationship with the WHO/GPA. Zambia is a large, sparsely populated country compared with Britain, which is about a third of the size of Zambia with seven times the population. Zambian *per capita* Gross National Product (GNP) was only US$250 in 1987, making it one of the poorest countries in the world (World Bank Report 1989). It had a negative growth rate and a high annual rate of inflation. It was also heavily indebted, with a total external debt of US$6,400m, three and a half times its GNP of US$1,800m. The disparity in income has obvious implications in terms of health spending. The Zambian government's health budget at this period was only US$5.9 *per capita* (UNZA, 1997). Life expectancy was nearly 20 years shorter, partially reflecting much higher rates of infant mortality.

Table 4.1: Economic and political indicators in Britain and Zambia, 1987

	UK	Zambia
General		
Population (millions, mid '87)	56.9	7.2
Population growth ('80-87)	0.1%	3.6%
Area (,000 square km)	245	753
Economic indicators		
GNP per capita (1987)	$10,420	$250
Average annual growth rate ('65-'80)	1.7%	-2.1
Average annual rate of inflation ('65-80)	11.2	6.4
Average annual rate of inflation ('80-87)	5.7	28.7
Total external debt ('87)	n/a	$6,400m
Health indicators		
Live expectancy at birth (1987)	75	53
% babies with low birth weights	7	14
% of total state expenditure on health ('87)	13.1	4.7
Total state expenditure as % of GNP ('87)	39.9	40.3
Population per physician ('84)	870	7,100
Estimated % of adult population HIV+	0.087 (1994)	16/17%*
Overseas Development Assistance (ODA)		
ODA ('87)	$1,865m	-
ODA as % of GNP ('87)	0.28	-
Net ODA received from all sources ('87)		$429m
ODA as % of GNP ('87)		21.1

Source: World Bank Report, 1989

**Source: Rev. Professor Anne Bayley, personal records*

1. The policy environment in Britain

A. Policy network theory

Policy network theory has been used to describe the political context of a number of industrialised countries and has been thoroughly developed and applied in Britain (Rhodes and Marsh, 1992). One of the theory's basic premises is that policy environments vary between sector and over time and that this will impact upon the way that policy networks operate in particular circumstances. In general, however, Britain is described as having a tendency towards relatively closed, consultative government compared with other countries of similar income (Jordan and Richardson, 1982). Consultation is seen as important in order to simplify the policy process and to ensure the legitimacy of political decisions. The right to join consultations, however, is not a given and access to government is generally limited (Anand, 1997). Regularised access to government is granted only to those groups which abide by the 'rules of the game' (Rhodes, 1992). Rhodes (1986) has identified five broad types of policy network operating within Britain (see table below). This typology is not argued to be exhaustive, and it is stressed that the types mentioned are not hermetically distinct. Any particular policy area may include facets of more than one broad type of policy network.

Table 4.2. Policy communities and policy networks: the Rhodes model.

Type of network	**Characteristics of network**
Policy community	Stability, highly restricted membership, vertical interdependence, limited horizontal articulation
Professional network	Stability, highly restricted membership, vertical interdependence, limited horizontal articulation, serves interest of profession.
Intergovernmental network	Limited membership, limited vertical interdependence, extensive horizontal articulation.
Producer network	Fluctuating membership, limited vertical interdependence, serves interest of producer.
Issue network	Unstable, large numbers of members, limited vertical interdependence.

Source: Rhodes, 1986

Policy communities are characterised by relatively stable relationships between a highly restrictive membership. Members of a policy community are dependent upon each other because of their shared service delivery responsibilities and are insulated from other networks and from the public, including parliament. All members of the policy community have a high level of resources and their relationship is based on resource exchange. Professional networks are characterised by the pre-eminence of professionals in policy-making. Professional groups enjoy significant power within the policy process due to their virtual monopoly of expertise and a tightly controlled system of entry to their ranks. These networks manifest a substantial degree of vertical independence whilst insulating themselves from other, non-specialist networks. Inter-governmental networks are based on the representative organisations of local authorities and have a broad association of interests that includes all local authority services. Producer networks are dominated by economic interests, whether public or privately controlled and are heavily dependent on industrial organisations for delivering goods and expertise. The term issue network is used to refer to the policy areas that encompass a broad range of groups, all of which have an interest in a particular policy area but who have very varied levels of interaction with each other. Issue networks have a correspondingly limited degree of consensus.

B. The health service and policy networks

The health profession is the most frequently cited example of a professional network (Rhodes, 1992). Through their professional monopoly, doctors are thought to enjoy relatively autonomy from, and power over policy-makers. Professional groups are in a relatively strong position to influence the policy process. In a differentiated society, specialised occupational skills "create relationships of social and economic dependence" which strengthens professional groups' influence over policy outcomes (Johnson, 1972; 41). The medical profession, with its virtual monopoly over highly technical, specialised and important skills has a vital and dominant role in the health field (Larkin, 1988). The government is reliant on members of the medical profession not only for the

information they can provide but also their co-operation in implementing policies, since doctors are crucial to the delivery of healthcare.

Is this, however, an accurate picture of the health policy environment? Smith (1993) argues that though doctors have important resources they are not necessarily able to dominate the policy process. In a comparison of healthcare in Britain and the United States he demonstrates that the relationship between government, the medical profession and policy outcomes is highly varied, dependent on a range of factors. In the US, doctors have proved unable to consolidate a strong autonomous centre of power. State intervention in health has tended to be limited and *ad hoc*. This has created a relatively hostile relationship between doctors and governments. The US's federal system creates a relatively fragmented system of political sovereignty and decision-making authority is divided among legislatures, executives and courts. The predominantly private system of health care has meant that insurance companies have become an enormously influential voice in the policy process. Overall, the health arena has so great a range of semi-autonomous participants, with such divided opinions and interests that the system effectively amounts to an issue network.

In Britain, Smith argues, the fact that medical professions have a relatively dominant position in health policy-making is very largely a factor of the way the National Health Service (NHS) evolved. Before the NHS was created, decision-making power was divided between privately endowed hospitals, the state and a relatively fragmented medical profession. When the post-war labour government began to broach the idea of a new, state-run health service they found that the number of relatively powerful participants in the health arena made achieving consensus almost impossible. It was only by nationalising hospitals and thereby removing private hospital trusts from the equation that real progress was made towards achieving a comprehensive health service that was free at the point of entry. In so doing, however, they put considerably more power into the hands of health professionals. There followed a series of compromises made with the health profession – for example giving them clinical autonomy, which made them the main arbiters of health spending and guaranteed them a central place in policy-making.

The effect of these compromises was to enable the development of a closed policy community between the Department of Health and health professionals.

Smith goes on to argue that during the Eighties this health community was the subject of serious attack by Prime Minister Margaret Thatcher, whose government had been elected on the basis of cutting public expenditure and reducing the role of the state. By the mid- to late-eighties, Britain's National Health Service was in serious financial and management difficulties. The Griffiths report of 1983 had heavily criticised the NHS's policy of 'consensus' management and in particular management's heavy reliance on doctors – rather than people with known management skills. By the second half of 1987, after a third consecutive Conservative general election victory, it was well publicised that wards were regularly closing down for lack of funds. By the end of the year, the Royal Colleges had issued a warning that serious action needed to be taken (Wall and Owen, 1999).

The government's perception of these problems in the health service was based on a new-right ideology. Dismissing claims of under-funding, they argued that inefficiency and the insinuation of special (professional) interests into government were the real causes of the growing problems in health service delivery (Powell, 1976; Goldsmith and Willets, 1988). The result was a series of measures that were explicitly aimed at reducing medical control over the health service. After failing to reach agreement with the British Medical Association the government announced a system of cash limits and internal markets in order to control expenditure. A new *cadre* of managers was introduced to separate spending decisions from a purely clinical standpoint. Finally in 1988, a review of the Health Service was carried out by a small group of politicians, civil servants and advisors from new right think tanks such as the Adam Smith Institute and the Centre for Policy Studies. No representatives from either the BMA or the Royal Colleges were included on any of the working groups. Klein points out that "the review was a private affair. It was designed to produce policy options for the Prime Minister, not a consensus about the NHS" (Klein, 1989: 237).

These actions, Smith argues, were to radically undermine the health policy community. Though doctors still have influence, the health policy arena has moved from being a relatively closed policy community to an issue network involving more participants and a wider spectrum of opinions. The following chapter will discuss how the Global AIDS Strategy impacted upon this changing political landscape. It is also an interesting example of the exercise of agency and structural power to achieve particular goals. Both the post-war and Thatcher governments showed political acumen and independence of thought to achieve change. They were, however, ultimately only able to do so because they were able to change the administrative and legal structures within which conflicting groups operated. Their agency power was underpinned by structural advantage.

2. Sub-Saharan Africa and the 'developing country policy environment'

The political environment in developing countries has become an increasingly important focus of research in recent years, spurred on by the desire to explain the on-going under-development of low-income countries. Why is it that a succession of development interventions over the last thirty years has largely failed to generate economic growth within a stable political environment?

The last decade has seen a growing consensus within donor organisations that on-going underdevelopment is the result of a failure in governance. Governments in developing countries have come under increasing attack for resisting pressures for democratisation, for endemic corruption, clientalism and state-centred inefficiency. In 1989 the World Bank made a firm statement that unstable policies, public institutions and the misappropriation of funds by political elites for their personal gain were at the heart of sub-Saharan Africa's economic crisis (World Bank, 1989). Since then donors have made government reform and a net reduction of the state's role a key development target (Batley, 1999).

Over the last ten years Africa has seen a wave of democratic reforms, including the introduction of multi-party elections in almost every country in the continent, the lifting of press restrictions and the removal from power of hitherto impregnable national 'fathers'. In part, these political changes have been brought about by internal campaigns against authoritarian governments (Strange, 1996; Bratton, 1994; Young, 1993). Civil society organisations have played a part in lobbying for reform and their profile has risen accordingly. These indigenous pressures for reform have, however, received considerable support from external agencies, particularly in the form of political and economic pressure from the donor community. The collapse of the Berlin Wall helped to generate a consensus that liberal democracy was the most effective way of promoting economic and political stability. Equally, it marked the end of the Cold War. Corrupt, abusive governments that had learned to rely on support from the West or the Soviet Union in return for political alignment suddenly found themselves isolated and unable to withstand mounting pressure for reform.

The donor community has tried to encourage political reform by various means including making it a condition of lending and debt relief (Hearn, 1999). Multi-party democracy, bureaucratic accountability, a reliable judicial system and freedoms of association, information and expression are seen as pre-conditions of competent government (Landell-Mills and Seralgeldin, 1991). Constitutional reform is, however, seen as being only one part of the process of democratic consolidation. Civil society organisations are being actively encouraged by adjustments in aid flows towards the independent media, NGOs, human rights organisations, electoral committees and opposition parties (Hearn, 1999). There has been a considerable rise in the activity of local organisations over the last decade. Economic and political liberalisation has increased the number of businesses, business associations and independent media. State retrenchment has led to an increase in local self-help groups, supported and often catalysed by larger NGOs. The wave of social and economic problems that has hit Africa, compounded by food insecurity, government retrenchments and the AIDS epidemic has meant that locally-organised groups are becoming increasingly important providers of support and services. The Global AIDS Strategy's

recognition of the contribution of non-government organisation is a reflection of a wider donor trend towards more inclusive interventions.

There is, however, a debate about the extent to which these forms of support have genuinely fostered a more democratic, inclusive policy environment. Recent elections in Africa have been strongly criticised for being flawed or unfair, essentially remaining a forum for on-going power struggles rather than the construction of democratic institutions (Ottaway, 1997). In many states existing elites have been able to use the 'advantages of incumbency' to retain power (Strange, 1996; Bratton, 1994). There is considerable doubt about whether five-yearly multi-party elections are an adequate means of ensuring accountable government in regions where the activities of urban-based political parties seem far removed from the day-to-day realities of the majority of the population (Bratton, 1999). Similarly, attempts at supporting local, non-government organisations have been criticised for killing the spirit of 'voluntarism' with which small organisations were formed (Wallace, Crowther and Shepherd, 1998). The requirements of donor accounting procedures entails establishing accounts departments and a cadre of professional staff who are likely to come from relatively prosperous and well-educated households. External funding can also risk shifting staff's primary affiliation away from its members. Staff will put forward proposals that they know will satisfy donors, rather than acting as advocates for its membership (Robinson, 1996).

Given industrialised countries' apparent monopoly over structural power compared with developing countries, we might expect that it would be possible for them to ensure that their poorer neighbours comply with particular policies. Such assumptions underpin the increase in conditions that are put on lending and debt relief. Yet despite this, the governments of developing countries retain considerable scope to avoid or adapt donor prescriptions (See, for example, Moseley *et al*, 1995). The result is something of an impasse. Donors blame undemocratic, clientalist governments for the failure of development interventions. Yet at least partly because of the same problems, development interventions designed to improve government performance often meet with failure.

Explanations for this on-going failure depend on one's understanding of the underlying cause of this tendency towards unaccountable, authoritarian government. Explanations fall across a spectrum of opinion. At one extreme are those who argue that it is largely due to a cultural predisposition to authoritarianism. At the other, are those who argue that the causes are essentially external to developing countries. The shared experiences of colonialism, capitalist penetration and state formation in a dependent position in the international capitalist economy fostered the conditions for state elites to take political and economic control.

For obvious diplomatic and political reasons, arguments that authoritarianism is innate in developing countries are underplayed by international organisations. They are, however, implicit in much of the writing on good governance. The World Bank's (1989) statement on corruption was a relatively rare example of an international organisation giving its frank appraisal of the underlying problem. Various authors, however, claim that 'development discourse' is underpinned by what they would regard as eurocentric and value-laden biases (Mohan, 1997; Ferguson, 1990). Even the neo-populism championed by Robert Chambers has been criticised for its rosy, eurocentric caricatures of rural people from developing countries (Brown, 1998). Positive stereotypes of the community-minded, traditional peasant culture are readily inverted to become a set of cultural 'obstacles' for effective, populist development interventions (Brown, 1998). Cultural-predisposition arguments were also surprisingly common at the expatriate social occasions I attended during my five months' fieldwork in Zambia. Senior representatives from a number of UN organisations, NGOs and bilateral agencies forcefully expressed the view that it was the 'African way' to misappropriate funds for personal gain.

The academic literature has also seen a resurgence of cultural explanations for corrupt and inefficient government. For some, Africans' traditional loyalty to their tribal kin undermines the development of a democratic and pluralistic society (Gellner, 1994). Unlike the 'modern' man of Western democracies, the centrality

of primary affiliation in 'traditional' societies means that their citizens are unable to be neutral in office and their ability to develop other sorts of identity – based on their class, their profession, their club membership and so forth is compromised. In a similar vein, Bayart (1993) argues that African politics are characterised by a zero-sum attitude to power that predates colonial rule. Politics can be seen in terms of elites struggling for power according to a zero-sum logic. Economic scarcity has led to the politics of 'extroversion', persistent attempts by African leaders to supplement their own resources with those from outside. Thus, potentially competing elites can fuse together to form a single dominant class centred on control of the state. In Uganda, for example, for several years after independence multi-party elections were made meaningless by the way in which political elites switched parties or formed coalitions so as to remain in power (Mamdani, 1976).

Primary affiliations certainly remain a critically important part of African social relations. Such affiliations fall in to four main types; groups based on kinship, territory, traditional political affiliation and cultural affinity (Chazan *et al*, 1992). Kinship ties are perhaps the most important social relation and also have economic implications. Ties set up expectations and obligations and many economically successful Africans will be aware of the expectations of their extended families. Kinship ties are also closely linked with affiliations based on territory or geographical community, which remain significant despite the drifts of migrant labour and urbanisation. Home-town organisations are prominent forms of urban social organisation.

Networks based on kinship and territoriality are often linked to traditional political institutions such as chiefs. Though these have been altered radically by colonial rule and independence, they remain an important factor of African political life. Even now rural land in Africa is frequently allocated by hereditary chiefs (Scott, 1998). In rural areas they are often the most visible form of government and have *de facto*, if not *de jure* responsibility for day-to-day affairs. As custodians of traditional culture, they also wield significant influence over the attitudes and

expectations of their constituents. Cultural biases, such as against women or young people, can be reproduced by traditional political structures (Scott, 1998).

Notwithstanding the obvious significance of traditional African political structures, however, the argument that corrupt and paternalist government is an inevitable consequence of these structures has significant weaknesses. In the first place, prior to colonial rule Africa was comprised of numerous, often mobile ethnic groups with very different patterns of behaviour and levels of contact with outside groups. It is hard to see how one innately 'African' pattern of behaviour can emerge from such diversity. Secondly, it over-estimates the neutrality of Western systems of social organisation (Etzioni, 1993). A sense of community, kin or clan identity does not necessarily compromise other forms of affiliation. Precisely because ties based on community and kin are personal and specific, it follows that they are not all-embracing and do not impede other forms of affiliation and identity action. Finally, these approaches tend to underplay the variety of effective, independent organisations and institutions of contemporary Africa (Hearn, 1999, Healey and Robinson, 1992).

At the opposite end of the spectrum are those who argue that the problem is a result of external factors in general and capitalism in particular. The penetration of capitalist modes of production into the developing world simultaneously exacerbated differences in income and status and created the conditions for an authoritarian state. Alavi (1972) uses a class-based approach to understanding administrative structures in developing countries. In the post-Colonial state, he argues, the base of the state apparatus inherited at independence was that of the colonial metropolis. It represented class forces in the colonial power and was specifically designed *not* to represent the interests of any one of the indigenous classes in the society. When the colonists withdrew, the bureaucracy began to rest on the support of two classes, the landed classes and metropolitan elites. In effect, it mediated between the interests of these two factions. These factions, however, were sufficiently weak to allow bureaucracy some degree of autonomy. Hence an 'over-developed' state that appropriated a large part of the economic surplus for use in bureaucratically directed 'development' activity. Saul (1974) picked up this

line of argument, arguing that in Tanzania, unlike Pakistan about which Alavi's arguments were based, there were no strong indigenous classes to be subordinated. Instead, bureaucrats sought to subordinate pre-capitalist social formations. Administrators, he argued, could be seen as a class in their own right, acting in their own interest to appropriate the means of production.

Some authors caution against over-emphasising the autonomy of the administration in Africa, arguing that states there have neither effective authority nor functioning state structures (Sandbrook, 1985). Others differ with Alavi and Saul by arguing that the administration does not now constitute a distinct class, but simply presented a new arena for power battles between existing elites (Leys, 1976). What such arguments do, however, is to draw attention to the ways in which political power has accumulated in the hands of a well-placed minority, and to some of the obstacles to creating independent, autonomous organisations that represent broad sections of the population. They also have very negative implications for the success of development interventions. Ferguson (1990) argues that 'development activities' in low-income countries achieve nothing other than to extend bureaucratic control and income inequality into remote, poor regions.

The polarised debate on whether unrepresentative government is the result of colonial imperialism or African croneyism is overdrawn. It is perhaps more useful to see the problem as one of co-determination. The on-going under-development of in low-income countries is the result of a complex mixture of indigenous and exogenous factors evolving over many decades (see, for example, Chazan *et al*, 1992; Hyden and Bratton, 1992). The circumstances of colonialism and subsequent independence uprooted traditional institutions of political accountability and replaced them with structures that focused political and economic power in the hands of a weakly-accountable and politically insecure minority. In effect the grafting of alien institutions to societies that have evolved from different cultural and political systems have created hybrid administrative cultures and structures.

Grindle and Thomas (1991: Chapter Five), argue that though developing countries are clearly different in terms of their socio-economic and cultural backgrounds,

their common experiences of colonisation, de-colonisation and relative dependence in the global political economy has created certain features which can be cautiously generalised as the developing country 'policy environment'. These policy environments are characterised by the presence of a relatively small number of decision-makers with a disproportionate influence over policy evolution. Developing countries tend to have dispersed and relatively youthful populations with high levels of illiteracy. This has the effect of concentrating power in to the hands of an educated elite. To a large extent, these elites operate within state organisations.

The process towards authoritarianism was assisted by the centralised institutions governments inherited at independence (Mamdani, 1976). Colonial government set a precedent of absolutist and centrist government based on the needs of the metropolis. Economic resources in the colonial state tended to be narrowly based and heavily dependent on the world market. In some cases, ailing traditional systems were invigorated by the wealth that colonial rule brought with it, serving to exacerbate social and economic stratification (Mamdani, 1976). Britain's policy of 'indirect rule', for example, deliberately exploited traditional leadership systems to consolidate colonial authority (Laitin, 1985).

Approaching independence, colonists' strategic imperative was to identify "potential political and administrative elites who could gradually be trained to assume the enlarged responsibilities of the colonial state" (Young, 1988: 53). The relatively small number of Western-educated people found careers in state institutions. The Soviet Union provided an important role model for newly industrialising countries and, in the context of the Keynesian political climate in the West, development aid was targeted towards developing a competent central administration. The result was to create a civil service with a disproportionate influence over the allocation of resources. Donor funding was critically dependent on producing a development plan and import-substitution was considered to be the best way forward for developing countries. This could only be achieved through state control of the economy. In a pre-industrial nation, the state was considered

to be the only economic unit large enough to catalyse the process of rapid industrialisation.

While economic and political power has been concentrated into the hands of a relatively small number of people, the relative paucity of information upon which to base policy decisions has meant that decision-making tends to be based on intuition and experience rather than solid empirical evidence (Grindle and Thomas, 1991). This in turn means that political and economic decisions are relatively easy to challenge. Policy outcomes are thus a function of who has the most political power. This problem is exacerbated by the conditions of underdevelopment, with relatively large demands being placed on the public sector and relatively few resources with which to meet them. Heavy dependence on primary exports makes the economy highly volatile. Reliance on imported manufactured goods makes developing countries vulnerable to changes in the world economy. The result has been relatively high levels of political instability compared with the industrialised North. With power and wealth concentrated within a small state elite, political participants have a high 'incentive to invest' in political disruption, while those in power divert funds towards maintaining support (Ake, 1973)

3. The policy environment in Zambia

Zambia is a typical example of the heavily indebted, low income, 'over-developed' sub-Saharan state. Zambia's political boundaries encompass twelve distinct language groups that had no political linkages prior to colonialism. Two kingdoms dominated the region in the 19th Century; the Lunda and Luba in the North, East and West of Zambia, and the Bemba in the South. Both kingdoms had complex economies, including mining, copper and iron smelting and regularly traded with the Portuguese. In the early part of this century, the British South Africa Company gradually secured control over the region. Originally, the area now called Zambia was seen as an appendage to Southern Rhodesia and was used as a source of cheap labour for the mines there. The introduction of a hut tax on all properties ensured that men of working age had to find wage-employment in farms and mines, at once

integrating them in to both the cash economy and the colonial administration. The British government administered colonial rule from 1924 to 1964.

Copper finds improved the colony's profitability and became its economic mainstay. Despite this, the state remained small with its emphasis on tax collection and the maintenance of public control. The civic structures of colonial and, later post-colonial society adopted Western models, evolving in response to white settlers, government and black urban class interests (Hamalengwa, 1992). This left a clear dichotomy between the institutions of government and urban society on one hand, and that of rural communities on the other (Copestake, 1998).

Despite radical economic and political changes in the past one hundred years, traditional systems of affiliation remain strong. Lineage and kinship remain the most important affective relationships in Zambia. Largely unacknowledged by government and donors alike, traditional headmen retain important powers in relation to land allocation and the settlement of civil disputes. A representative survey found that Zambians felt as strongly affiliated to chiefs and headmen as they did to modern political parties (Bratton, 1999).

At independence in 1964, nationalist leader Kenneth Kaunda was charged with the responsibility of ensuring that ethnic identities did not undermine the emergence of a modern, national identity. All too frequently, loyalty was secured through patronage within a centralised administrative system (Momba, 1989). In common with other African countries, Zambia adopted increasingly statist economic policies, a trend that was strongly supported by Keynsian economic advisors from the industrial economies. The majority of the country's revenue came from its state-owned mining interests, a situation that reinforced the culture of state patronage and dependency. In 1974 Kaunda introduced a single party constitution and as a result was to remain in power until 1991.

Zambia's economic and political history has been critically influenced by its dependence on copper revenues. British colonial policy towards what was then called Northern Rhodesia was the integration of the country in to the British

colonial plan. Zambia's 'comparative advantage' lay in its supplies of copper. Manufacturing and farming sections were neglected, shortfalls being augmented from other British colonies in Southern Africa. At Independence, copper accounted for 90 *per cent* of Zambia's exports, a figure which remained the same right up until the 1980s (Clark and Allison, 1989). Until the mid-70s, favourable copper prices meant that Zambia's dependence on copper remained relatively unimportant. The fact that Zambia's agriculture sector was unable to provide cheap food for its urban population could be tackled through government maize subsidies. The state provided employment in its extensive and often inefficient civil service.

In the mid-1970s, however, the price of copper fell at the same time as prices in imports, particularly oil, rose. By 1982 Zambia was having to sell four times as much copper to buy the same volume of goods as it had in 1970, yet copper reserves were rapidly depleting (Clark and Allison, 1989). Adverse terms of trade were compounded by serious problems of rent-seeking, corruption and inefficiency (Good, 1988). The government failed to utilise loans on its intended recipients and seriously mismanaged development programmes. At the same time, the gap between rich and poor were growing. Between 1975 and 1983, the top 5 per cent's share of national income rose from 35 to 50 *per cent* (Good, 1988).

In 1982, Zambia began embarking on a World Bank Structural Adjustment Programme, which had the explicit aim of cutting government expenditure. Despite this, internal and external pressures made cuts almost impossible. The government was forced to continue unsustainable employment and maize subsidies in order to maintain its dwindling public support. In so doing, government spending increased to over two times its revenue. On-going political instability in neighbouring Mozambique, South Africa, Zaire and Angola disrupted trade at the same time as increasing the country's expenditure on defence. Inflows of refugees put a further strain on state finances.

Zambia was also suffering from both internal and external debt. By 1984, Zambia was paying around 60 *per cent* of its foreign exchange earnings to service external

debt (Clark and Allison, 1989). The budget deficit was borrowed from commercial banks and the Central Bank of Zambia, which in effect meant fuelling inflation by printing more *Kwacha*, the Zambian currency. By 1985, the IMF had lent Zambia more than any other sub-Saharan country and by the end of 1986, it was more than $100 million in arrears. Zambia's repayment and interest on IMF loans alone were estimated at over 30 *per cent* of its export earnings (Good, 1988).

In addition to foreign debts, government agencies were increasingly becoming indebted to each other, adversely affecting their operations. In 1987, for example, the state-owned Zambia Airways Corporation owed the Department of Civil Aviation K1 million. By 1989, it owed K4.8 million, which it was paying off at the rate of K100,000 per month. Vital services at Lusaka's international airport were by then dangerously inadequate (Good, 1988). In 1986, the government owed the Bank of Zambia nearly K1,900 million in uncleared overdrafts, partly incurred to finance unconstitutional state expenditures, exceeding the allowable limit by more than K860 million (Good, 1988).

In late 1986, the IMF offered a short-term rescue package, conditional on a comprehensive set of financial policies designed to limit the budget deficit and reduce payment arrears on its debt. The currency was devalued, wages frozen and import-controls instituted. Copper prices continued to fall and the IMF loan package served to increase its debt load. Devaluation made debt service repayments more difficult. In 1987, total long term debt represented 227.5 per cent of GNP (World Bank, 1989).

On May 1, 1987, President Kaunda declared that the IMF programme had failed, that it was being abandoned and that the government was suspending its debt payments to the IMF and the World Bank. The flash-points were firstly IMF-backed foreign exchange (forex) auctions, which were thought to be diverting funds away from priority sectors in favour of foreign businesses and secondly, the phasing out of maize subsidies. Both issues provoked fierce hostility towards the donor community, who were seen as latter-day imperialists. In 1988, Zambia launched a combined 'New Economic Recovery Programme', the main aim of

which was to stabilise the economy and, by controlling inflation, increasing profits and investment. An important feature of the programme was that it involved imposing a limit on debt service of 10 *per cent* of forex earnings after the forex needs of the mining sector, airlines and oil and fertiliser imports had been deducted. Donors reacted quickly, cancelling promised aid programmes. Shortly after Kaunda stopped the IMF programme, Britain announced that it would withhold a grant of £9.3 million. West Germany, Britain and the US soon decided not to extend any further aid until a further deal with the IMF was agreed (Young, 1989). Economic conditions rapidly worsened, especially for the poor. In late 1987, about 18,0000 people were said to be facing starvation in the Luangwa district, with 65,000 in the same condition in the Mumbwa district west of Lusaka. Food riots became more common and were met with state violence (Good, 1988). Opposition to Kaunda and to single party democracy began to grow. The trade union movement became an increasingly important vehicle for political dissidents. Businesses were becoming increasingly unhappy about onerous state controls and financial mismanagement. The churches provided platforms for popular dissent.

In 1991, the government was effectively forced to hold its first multi-party elections since independence. Kenneth Kaunda was voted out by a broad-based opposition coalition known as the Movement for Multi-party Democracy (MMD) led by trade unionist Frederick Chiluba. This was a historic moment: the first time a head of state was removed by election in Anglophone Africa. Given its historical significance, voter turnout was surprisingly low at just 46% of the population. A mere 14% of registered voters took part in November 1992 local government elections. There remains a general suspicion of political parties and, particularly, the probity of many politicians (Bratton, 1999).

The high hopes of the general election have, in general, been met with disappointment. A culture of presidential croneyism reappeared with remarkable speed (Simulanyi, 1996). The shared goal that had held MMD's loose coalition together disappeared as soon as Kaunda was out of office. Increasingly, Chiluba began to rely on support from the influential Christian fundamentalist movement. The country was declared a Christian state in 1993 and began to attract investment

from fundamentalist Christians from abroad. In 1994 an evangelical Christian businessman from Britain chose Zambia to be the base of the African division of his successful second-hand car dealership as well as the site for a powerful new radio transmitter which was used to broadcast his 'Christian Voice Radio' across East Africa. Having found religion after a visitation from the deity in a car park in Dagenham, he regarded the on-going success of his commercial ventures as evidence of divine support for his particular form of 'Christian commerce'.[1]

In 1996, MMD were voted back to power in a second multi-party election. For many, the elections were flawed. Prior to the election Kenneth Kaunda's party UNIP refused to stand and Kaunda himself urged the public to boycott the election. Several observers, including the Zambian Independent Monitoring Team and the international NGO Human Rights Watch declared the election not free and fair by international standards.

A. The Health Policy Environment

At the time HIV/AIDS was first identified, Zambia was in the thick of acrimonious negotiations with the international community. This, combined with its dire economic situation had had a significant impact on health services. At a time when poverty was increasing, the health service (amongst others) was being cut back. Under the IMF programme, health represented a declining share of the government budget. It is estimated that the real value of the 1986 budget was only a quarter of its 1983 level (World Bank, 1986). For obvious political reasons, however, the government was loath to cut urban employment, so retrenchments have tended to occur in primary health — especially in rural areas — and on essential drugs (Clark and Allison, 1989). Health services were also affected by the problems of internal debt. In 1987, the University Teaching Hospital in Lusaka owed its main supplier, Medical Stores Ltd K8 million (Young, 1989). Poor pay and low morale had led to a significant outflow of qualified doctors. The shortages also affected non-government services. UNICEF claimed that all their programmes were affected by the crisis and that their immunisation schemes collapsed completely as transport

[1] Interview with general manager of Christian Voice, in 1994.

became difficult to obtain and fuel shortages affected cold-storage of essential drugs and vaccines (Clark and Allison, 1989).

Zambia's health service began to suffer dramatically. In the early 1990s, the Ministry of Health conceded that there were a series of inadequacies in the provision of health service. It was recognised that resources were being used inefficiently due to an over-emphasis on expensive hospital care and a corresponding under-resourcing of the most accessible facilities such as health centres (Simms, Milimo and Bloom, 1998). There were also substantial inequalities in health service provision. This inequality was partly urban/rural — a reflection of the concentration of health funding in hospitals. However, there was also an inequality between regions, caused partly by the way that donors tended to focus health interventions on particular regions or programmes (MoH, 1994). These problems had direct implications on health. Between 1980 and 1991 the proportion of Zambian children dying before reaching five years of age rose from 15 to 19 *per cent.* Over the same period, under-five mortality in Eastern Africa and Africa actually declined (Simms *et al*, 1998).

Summary

In this chapter, I have reviewed the policy literature on policy networks in Britain. In Britain, a relatively close health policy community was under assault from the right-wing government. New actors had been included in decision-making process and professional groups were deliberately excluded from key policy forums. Funding problems and health service delivery inequalities were causing real pressures on the National Health Service.

I then went on to discuss the policy environment in developing countries generally and Zambia in particular at the time the Global AIDS Strategy was operationalised. In Zambia, the political and economic environment was even more fraught. The country was reaching economic and political crisis. Debts acquired over the previous thirty years had brought the relationship between the government and the donor community to crisis-point. At the same time, the government was facing

considerable pressures for political reform, particularly from the donor community. Meanwhile, the majority of the population was undergoing a rapid decline in government services, standard of living and health status. In many rural areas, traditional forms of authority were at least as important as the remote, impoverished and largely urban government agencies.

Chapter Five:

Building a consensus: evidence, argument & persuasion

Introduction

In 1989, Majone published a critique of a particular form of quasi-scientific management literature that appeared to assume that policy-decisions are, or could be, the result of a rational, informed appraisal of different policy options. Such approaches, he argued, misunderstood the complexity and creativity of the scientific process. Rather than being clinically objective, scientific theories evolve out of process of thesis and antithesis. Scientists present competing theories to the scientific community and to the public until eventually some form of – often temporary – consensus is reached. The scientific community can not, for example, give us one clear, consensual answer as to the existence or, causes of global warming. Instead, we are presented with a range of competing theories as to its significance and potential impact. Experts use evidence and argument to persuade policy makers that theirs is the most plausible explanation for external phenomenon.

In the policy-making arena, this type of evidential ambiguity has far-reaching implications. In an already politicised process, the relative weight accorded to particular perceptions of problems will have significant implications on the nature and scale of policy interventions. Not only must experts show that they have a plausible understanding of an issue area, but they must show that a particular policy response can achieve a desired end. In an area like HIV/AIDS, where scientific knowledge was incomplete and contested, the level of access to decision-makers groups, the persuasiveness of their arguments and the perceived quality of their evidence are of crucial importance.

In this chapter I will discuss how the WHO AIDS programme built up a body of evidence which they then deployed to achieve a provisional form of international consensus about the scale of the epidemic. The chapter is divided into three

sections. In the first section, I will discuss the early responses to HIV/AIDS between 1981 and 1987. The WHO had a relatively limited involvement in policy development during this period. In both Britain and Zambia, a number of doctors, public health workers and specially-formed voluntary organisations established small issue networks, stimulating their respective government to organise responses to the emerging problem. In Britain, the problem was partly focused on finding ways of containing the growing public panic about the new 'plague'. Doctors and voluntary organisations in Zambia, who were seeing far greater numbers of AIDS patients, were concerned with finding low-cost methods of patient care.

In the second section, I will discuss how the WHO AIDS programme became an increasingly important repository of information and expertise about HIV/AIDS, providing a platform for international exchange of information on the issue. By presenting a clear, persuasive argument that HIV/AIDS was a serious, yet potentially controllable problem, the WHO helped to set the international AIDS agenda according to liberal, public health values. In 1985, the WHO set up a small department called the Special Programme on AIDS (SPA) to provide advice and technical support on issues as safe blood supplies and surveillance. From late 1986, however, the programme began to take an increasingly proactive role in publicising the issue internationally. During the period 1987-1989, the relationship between the WHO AIDS programme's organisational growth, and the growth of the international response to AIDS was iterative. As the programme became increasingly high profile within the international community so too did the issue of AIDS, which then began to attract increasing amounts of donor funding, thereby raising the profile of the WHO programme still further.

In the third section, I will discuss the organisational growth of the programme and the mobilisation of international funding for HIV/AIDS. By presenting HIV/AIDS as a serious, yet manageable problem of world health, the WHO became a logical conduit for donor funding. In 1987, the small WHO AIDS division became integrated into the administrative structure of the WHO as the Global Programme

on AIDS (GPA), receiving undesignated donor funding in its own right and launching its own programmes.

1. The early responses: 1981 - 1987

The development of AIDS policies has been presented as a rational bureaucratic response to a situation that had the potential for significant political and economic disruption (Day and Klein, 1989). Its mature responses certainly had elements of this form of top-down approach. The earliest stages, however, were very largely bottom-up, the result of informal alliances between public health doctors, scientists, clinicians and activists (Berridge, 1996). In both Britain and Zambia people who shared an interest in AIDS began to form small issue networks, pooling their knowledge, experience and interest to generate solutions to the emerging problem.

What is now known as AIDS was first observed in West Coast US. Young gay men were starting to present unusual symptoms, which were soon followed by a rapid and dramatic physical decline and eventual death. It was initially thought that the phenomenon was associated with the 'gay lifestyle', but there soon developed a serious epidemic in New York which was associated with poor inner-city communities, particularly IV-drug users, their partners and children. Gradually, the link with sexual transmission, blood and blood products was made. Though the clinical course of the new disease was clarified in 1982, the retrovirus (later called HIV), was not identified as causally associated with AIDS until 1983 (WHO, 1987). The first reliable diagnostic test did not become available till 1985.

This early period of scientific uncertainty about what the disease was or how to control it meant that the clinical responses to AIDS were largely *ad hoc*, the result of small numbers of interested clinicians responding to this influx of new illnesses. Importantly, however, the nature of the both NGO and medical responses to HIV/AIDS were very much affected by the organisational cultures and structures that were in place when AIDS first manifesting itself.

A. The grass roots response in Britain.

i. The medical response

The first diagnosed case of AIDS in Britain was reported in *The Lancet* in 1981. Thereafter more and more cases started being identified, mostly through Genito-urinary Medicine (GUM) Clinics. From the patients' point of view, GUM clinics had the advantage of providing confidential, open-access healthcare. Gay men could be assured that they could remain anonymous if they so wished and did not need to have a referral from their General Practitioner (GP). GUM clinics had a long tradition of non-judgmental treatment dating back to report by the Royal Commission on Venereal Diseases during the First World War (Berridge, 1996). Here, Britain first evolved its pragmatic public-health line on sexually transmitted diseases. It was in the overall public interest to provide confidential treatment for people, because to do so would lessen the risk of a wider epidemic.

Clinical responses to the new cases were focused in three London hospitals: St. Mary's, the Middlesex and St. Stephen's. Doctors with a growing interest in AIDS represented a wide range of specialities: from GUM specialists, through epidemiologists, virologists, gastro-enterologists and dermatologists. Gradually, loose networks began to develop between professionals involved with AIDS. An AIDS collaborative group was established and began to meet monthly. A small number of experts became what have been termed AIDS 'missionaries' touring around meetings and conferences trying to generate interest in the problem and find solutions to it (Berridge, 1996). In May 1983, the Lesbian and Gay Switchboard organised the first national conference on AIDS in the UK. An audience of around 200 people attended, who were in essence the AIDS issue network (Berridge, 1996). Doctors, epidemiologists and gay activists listened to a speech given by the director of the Gay Men's Health Crisis from New York and had a chance to swap information. Afterwards, the Gay Medical Association drafted an educational leaflet for GPs that was paid for and distributed by the Health Education Council.

Despite this growing interest, official funding for AIDS research started relatively slowly. Academic clinicians were responding on an essentially individual basis to the new and poorly understood problem. The first official Medical Research

Council (MRC) grant for AIDS-related research went to Anthony Pinching at St Mary's in 1983. The MRC then decided to set up an AIDS working party that began its work in October of the same year. This committee was advisory only, its terms of reference being to review knowledge of AIDS in the UK and abroad, and to encourage contacts between researchers (Berridge, 1996). A Commons Social Services Committee was later to criticise the committee for being slow in its response to AIDS and for turning down requests for research projects "with great potential...with minimum or no justification being given" (HSMO, 1987: 30). It was found that the burden for AIDS research had fallen on individual clinical academics "taking a very severe personal toll on those working with it in the face of continual cash shortage and staff under-resourcing (HMSO, 1987: 25).

To a great extent, the delays in funding are a reflection of the MRC's organisational history. A traditionally responsive supplier of research funding, the MRC's allocation for AIDS was roughly appropriate to the relatively small number of AIDS cases that had been recorded (Berridge, 1996). In the interim, it seem that the "clinical academic structure has managed to retain a flexibility which the general provision of NHS services has lost" (HMSO, 1987: 25).

ii. The NGO response

The medical profession was not alone tackling AIDS. The voluntary sector raised a raft of well-organised and high profile responses to HIV/AIDS. The AIDS self-help movement was started with the death of a gay man called Terrence Higgins in the summer of 1982. In the final stages of his illness, medical staff used double-barrier nursing methods, which caused extreme concern amongst his friends, gay activists and interested medical staff alike (Berridge, 1996). The isolated and demeaning circumstances of his death prompted his friends to form an organisation, the 'Terry Higgins Trust' in November 1982. The organisation was originally formed to raise funds for medical research. It soon, however, began expanding, becoming a major advocate and service-provider in its own right. In June 1987, after an acrimonious meeting with the original founders, the Trust was re-organised into a new, more formal 'Terrence Higgins Trust'. It had five key action areas: fund-raising; media and information; medical social services (the

origins of the buddy scheme); social services and finally, financial work. Body Positive, a self-help group for people who had been diagnosed HIV+ provided another model of AIDS NGO. Started in 1984, Body Positive established various local groups around Britain.

The response to HIV/AIDS from the gay community has to be seen in the light of pre-existing policy objectives and debates (Berridge, 1996). Gay organisations had developed clear health dimensions to their advisory and counselling activities — self-help groups such as Group B for those who were hepatitis B carriers were already in existence. The response to AIDS thus fitted into pre-existing gay medical and health paradigms. It provided a gay organisational and political focus which was lacking after the disintegration of some of the gay political organisations such as the Campaign for Homosexual Equality by the early 1980s (Berridge, 1996).

Increasingly, these organisations began to work with government to provide services to people affected by AIDS. From late 1983, the new Chief Medical Officer Donald Acheson began to draw gay representatives into an informal alliance with government. They were invited to meetings at the Department of Health[1] (DoH) and began to receive small amounts of funding from the department. The London Lighthouse was particularly well funded, and essentially took on a role of health service provision, providing government-subsidised care for the terminally-ill. Staff from the Lighthouse worked closely with government, and were invited discuss their experiences with senior members of the Ministry of Health, including Health Minister Norman Fowler.[2]

To a large extent, NGOs were used "because they were there."[3] Both Department of Health and NGO representatives acknowledged NGO's relative expertise in the new area in the interviews. Surprisingly, however, the Conservative government also found some common ideological ground with AIDS activists. Andrew

[1] In 1988, the Department of Health and Social Security was divided into two separte ministries. The health section subsequently became known as the Department of Health.
[2] Interview with Director of the London Lighthouse.

Henderson, director of the government subsidised London Lighthouse describes a sub-group within government as having been supportive of direct service provision from NGOs, because of the Conservative antipathy to the "proliferation of local government."

The period was, however, marked by tension between different sections of what is sometimes, somewhat glibly, termed the gay 'community'. AIDS provided a clear opportunity for the 'moral majority' to attack the gay social and political agenda, as well as 'remedicalising' homosexuality. For some, particularly members of the Terrence Higgins Trust, the best way to help gay men was to form alliances with government. For others, this course of action was to erode some of the achievements of the gay movement, a regressive move towards the remedicalisation of AIDS. There was a real fear that co-operation with the state would lead to eventual co-option. Some of the Gay Switchboard volunteers remained deeply suspicious of collaboration with government (Berridge, 1996).

Though some NGOs moved towards a more mainstream, service-provision role, lobbying was still seen as being one of their most important roles. "HIV and AIDS exposes those things in society that could be called the opposite of the feel-good factor. It's easy for governments to say 'Ah yes'... but actually nothing happens."[4] "I can't remember any civil servant ever saying... 'We are doing this because of the UN resolution'... Action happened when people chained themselves to railings, or we had a big march."[5] Even amongst those NGOs who worked with government, there was still an anxiety about the tension between the two roles, "Once a door opens, you actually get co-opted into the process anyway."[6]

This tension remained a key dilemma within the AIDS voluntary sector. THT director Tony Whitehead was later to regret their instinct to look after AIDS patients rather than taking to the streets in the way US groups had done (Berridge, 1996). Notwithstanding, the balance of power in relation to AIDS slowly shifted

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[3] Interview with Director of the Terrence Higgins Trust, London.
[4] Interview with Director of Impact, London.
[5] Interview with Director of the Terrence Higgins Trust, London.

towards the Terrence Higgins Trust's approach. By early 1984 the Trust moved to offices in London and by February had begun to operate a help-line. It also became the first explicitly gay organisation to receive charitable status and by 1985 was hiring full time staff.

iii. The establishment of the liberal line

In the first two years after AIDS was first identified in Britain, the issue was very much a minority concern of a small number of people who had been directly affected. From 1983, however, things began to change as cases began to arrive in greater numbers. A BBC Horizon programme *Killer in the Village*, showed how what was then referred to as AIDS was affecting the gay community in Greenwich Village in New York. The programme was widely discussed and the London Gay Switchboard reported being 'inundated' with calls from gay and straight members of the public.

By 1985, the antibody test had revealed an 'iceberg' of further cases. That and the revelation that heterosexual spread was not only possible, but very common in other parts of the world made AIDS a serious public and political issue. The political struggle centred around the tension between liberalism and a focus on individual rights on one hand, and more punitive but also essentially collective responses on the other. Public health officials and gay activists alike wanted to adopt a non-punitive approach, which did not stigmatise people affected by AIDS. This was a pragmatic as well as ethical stance. From the public health point of view, to confine people with AIDS, or to criminalise or re-criminalise behaviours associated with the transmission of HIV would drive the problem 'underground'. The atmosphere of intolerance would deter people that may be at risk from the virus from coming forward for testing, advice and support. From the political activist viewpoint, AIDS threatened to provoke a backlash against gay people and a consequent escalation of violations of their human rights.

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[6] Interview with Director of the Terrence Higgins Trust, London.

There was, however, intense pressure for a punitive response to HIV/AIDS. This came in part from the media and public opinion, however it also came from professional groups within the health sector. The Advisory Committee on Dangerous Pathogens (ACDP) laid out guidelines in January 1985, advising the use of disposable plastic aprons, gloves and eye protection, and limiting post-mortems only to the strictly necessary. Health professionals were extremely anxious about risk of transmission to HIV/AIDS. Cases were recorded of live patients being transported in plastic bags, of hospital staff refusing to work with AIDS patients and of putting up their own AIDS 'warning' signs above patients' beds (Berridge, 1996).

Despite this, 1985 saw the early construction of a liberal response through Department of Health and Social Security (DHSS) policies and in particular the influence of public health lobbies and Chief Medical Officer Donald Acheson. Health Minister Sir Norman Fowler is often credited with spearheading Britain's relatively energetic response to HIV and AIDS. However, his interest in, and approach to AIDS was heavily influenced by a small group of senior health bureaucrats at the DHSS, including Donald Acheson. Policies, Acheson explains, were not based primarily on human rights arguments, but on the 'driving-underground' arguments learned from their experience of dealing with infectious diseases. Others shared this perception that liberal AIDS policies were informed primarily by a medical consensus on the optimal way of handling infectious diseases. "There is a tendency to suggest that the gay community agenda was highly influential. Not really. I think liberal medics were far more influential."[7]

In 1986, a Cabinet Committee was formed to look into the matter, chaired by the then Deputy Prime Minister, Willie Whitelaw and including Norman Fowler, the Education Secretary Kenneth Baker, Nick Edwards the Welsh Secretary and Malcolm Rifkind the Scottish Secretary. The same year, a group of senior health bureaucrats at the DoH organised an international tour that had the specific intention of shocking government ministers into action. It started with a trip to the

[7] Interview with Director of the Terrence Higgins Trust, London.

WHO offices in Geneva, where Norman Fowler describes hearing a "sobering account of how Jonathan Mann, [who later became director of the GPA], saw the world-wide position ...[B]y 1992 there would be over half a million deaths from AIDS – and the total could rise to as high as three million" (Fowler, 1991). Visits to Berlin, Amsterdam and San Francisco reinforced the scale of the problem and showed him examples of essentially liberal, predominantly NGO, approaches to the problem.[8]

This pressure from liberal public health bureaucrats found a sympathetic audience amongst a sub-group of government whose outlook was essentially liberal-paternalist. Norman Fowler was certainly deeply affected by what he saw. Donald Acheson remembers him saying that if, in twenty years time, he would think 'I did too much' he wouldn't mind. But he would never for give himself if he thought he hadn't done enough. Sir Norman himself describes finding "the antipathy towards AIDS sufferers incomprehensible. Disease is disease whether it is sexual or not... You do not have to condone the conduct to want to help the casualties" (Fowler, 1991: 250). Acheson regarded Willie Whitelaw as having made an important contribution to maintaining the liberal line on AIDS policies. A commanding presence, he made sure the matter was taken seriously and that fellow Cabinet members paid attention. On one occasion, when there was talk of making Commonwealth scholars have mandatory HIV tests, Acheson remembers him as having been quite adamant, "He just said 'No. We can't do this'". Robert Armstrong the Cabinet Secretary was also regarded as important in this respect. As one of the most senior bureaucrats in the country, he had ensured AIDS was given sufficient Cabinet time.

In June 1986, an *ex urbe* dispatch was sent to the Cabinet Office from the High Commissioner of Zambia. Written in "remarkable prose"[9], it said that between 30-40% had been found positive on the test sites. The virus was clearly transmittable by heterosexual spread and it was by now clear that AIDS could become a serious problem amongst the general population. On September 21, 1986, the *Daily*

[8] Interview with Donald Acheson, former Chief Medical Officer.

Telegraph used the leaked document as evidence to support the introduction of screening for African visitors. Other paper's picked up the story and lurid articles foretold the possibility of an epidemic. As information about the disease leaked out, public anxiety began to grow. Acheson remembers a 'wave of terror' about risk of transmission from beer mugs, coughing and sneezing. Doctors reported increasing numbers of patients coming to them for help and advice and politicians were being quizzed about the problem in their constituencies. There was a considerable lobby from within and outside parliament to deal with the problem quickly.

The lobbying was, however, relatively dispersed and poorly organised, coming in the form of newspaper leaders, tabloid exposures and disapproval from individual ministers, MPs and members of the public. It could not provide a convincing framework from within which to organise public responses to HIV/AIDS.

> What emerged was a triumph for a particular form of liberal consensus around AIDS, for traditional modes of health policy making which had long been heavily reliant on the power of the medical profession, but which Thatcherite reforms presumed to have overturned, for an elite rather than a populist view of what policy should be. This established a form of response with its focus on individual rights and responsibilities and on individual behaviour, which was all of a piece with the general trend of post-war health policy in Britain.
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> (Berridge, 1996: 55)

In early 1987, Britain launched its first "Don't Die of Ignorance" campaign. The campaign was frank and hard-hitting and emphasised the threat to all from HIV/AIDS. Despite this, there was only one formal complaint from the campaign, from an MP who had yet to read the leaflet. For Donald Acheson, 'it seems you're protected by medical degrees, to some extent, if it's clear you're acting responsibly'[9]. It has been argued that campaigns were deliberately designed to emphasise the threat to everyone so as to diffuse the threat of a public backlash against 'high risk' groups and to prepare the ground psychologically for

[9] Interview with Sir Donald Acheson, former Chief Medical Officer.

controversial moves such as the introduction of government-run needle exchanges (Day and Klein, 1989). Sir Donald denies that their strategy was so deliberate, "that makes us sound like Napoleon". In practice decisions were made on an *ad hoc* basis in response to the rapidly escalating problem or HIV/AIDS.

It is clear that Britain's response to HIV/AIDS was informed by the influence of liberal medical ideas. But these ideas were not shared by large sections of the public or even the medical profession as a whole. Neither were they, in themselves, the ultimate 'cause' of the development of HIV/AIDS policies in Britain. Liberal policies were formed where these somewhat controversial ideas found a niche in existing institutions and organisational structures. Firstly, Britain had a long-established set of liberal-paternalist *institutions*, whose connected rules "prescribe behavioural roles, constrain activity and shape expectations" (Keohane, 1986: 3). To a great extent, senior medics were trusted by government and public alike. The National Health Service provided a long-standing model of public, paternalist responses to health problems. More than that, however, these sets of institutions had spawned organisational structures — for example the network of anonymous, open-access GUM clinics — that supported such a liberal, paternalist approach to AIDS. Finally, liberal policies were formed where the individuals who supported them had the power to incorporate them into policy. Senior health bureaucrats enjoyed high-status jobs in government and significant influence in health policy development. Ultimately, pressure groups could only raise consciousness about particular issues. It was the health bureaucrats who were able to establish the trend of government policy.

B. The grass-roots response in Zambia

i. The medical response

Like Britain, the initial responses to HIV/AIDS in Zambia came from its medical community. In January 1993, Dr. Anne Bayley, a general surgeon at the University Teaching Hospital (UTH) began to notice an increase in the numbers of patients with Karposi's Sarcoma, a hitherto rare form of skin cancer which was particularly associated with older men in East Africa but which is common amongst people with AIDS. Dr Bayley had been accustomed to seeing a steady 8-12 cases a year.

In January 1983, however, she saw six new and atypical cases. Patients were younger that she would normally expect, were better educated and did not respond to the usual treatments. She saw several manifestations of the disease on the face and trunk, which she would not expect and there was a link with lung disease and cyanosis. By June 1983, she had seen a total of 13 atypical cases, three of which were women. Having had a special interest in the disease for several years, she was aware of the unexplained increase in Karposi's Sarcoma in young homosexuals in the US through medical reports. By mid-1983 she was beginning to make the link with her own patients. Her findings were written up in a paper for a meeting of the Association of East African Surgeons. Throughout 1984, and 1985, Dr. Bayley made contact with researchers from abroad to publicise the phenomenon. She sent samples to a researcher called Robert Downing from Porton Down, UK who was writing a paper on the subject in *The Lancet* . In December 1984, she invited a doctor from the National Cancer Institute of Bethesda, Maryland, to the March 1985 Regional Meeting of the Association of Surgeons of E. Africa to discuss cases of HILV III-related disease. In April 1985, Dr Bayley attended the First International AIDS Conference at Atlanta, Georgia where she interested a number of doctors in her findings.

By 1985, two years *before* WHO resolution 40.26 was ratified, Zambia first began official responses to HIV/AIDS. In July, a team of medics from the Centre of Disease Control in Atlanta came to do a study in Lusaka and the first cases of HIV were formally identified. Surveillance was done in a number of sentinel sites including the antenatal and STD clinics and the army. Overall, an alarming 15/16% of the tests proved HIV+. In November, Dr Bayley presented these findings at the first AIDS in Africa Conference in Brussels.

When the CDC team arrived, the medical school decided to arrange a meeting with the visitors, the Ministry of Health, and interested doctors. From this *ad hoc* arrangement, an AIDS Surveillance Committee was formed. By 1986 representatives from the UK's ODA, the London School of Tropical Medicine, the Wellcome Trust and the Zambian Medical Research Council and the Ministry of Health met to discuss the growing AIDS problem. In June 1986, a first mini-

conference on AIDS was organised in Lusaka. In 1987 a national poster campaign was launched by the government, around the same time that Britain started its 'Don't Die of Ignorance' series.

The WHO was not a primary catalyst to Zambia's response to HIV/AIDS during this period. On an individual level, Eric van Praag of the WHO's Lusaka office was described as a "benevolent, switched on and supportive presence", though a behind-the-scenes player. He provided letters of reference to support claims for donor funding and backed local interventions. Though, from 1985, the WHO gave technical advice to the Surveillance Committee and initiated a safe blood programme, it was not regarded as being particularly helpful as an organisation. One Zambian doctor recalls being told by the WHO representative of a neighbouring country in 1986 that Zambia had more pressing concerns with which to deal.

ii. The development of AIDS NGOs in Zambia

From 1986, a small number of interested Zambians and expatriates began to find ways of coping with the growing AIDS problem. For many people with AIDS and their families, there was little within their power other than to try and alleviate some of the symptoms and obtain what medical help was available. A small group of predominantly Lusaka-based professionals, however, had the resources and commitment to establish more organised interventions. A network of people who were involved in health welfare interventions in various forms began to encourage each other to develop strategies for coping with what was seemed set to become a very serious problem.

In late 1986 Christy Baker, a British doctor trained in Zambia started doing AIDS education in schools. Encouraged by her husband – a teacher – Dr Baker obtained permission from the Ministries of Health and Education to start awareness-raising sessions. Dr Baker was aware that children were likely to be most influenced by peer pressure. Thus, when two boys approached her after one of the sessions to ask her what they could do, she suggested they start a pupils' 'anti-AIDS club'. Pupils chose the mantra 'no sex before marriage, no adultery, be compassionate'.

Though deeply Christian, Dr Baker worried that this was a bit naive. However, she maintains that it was very much the children who dictated the moral direction of the clubs. The idea of the clubs soon spread. Norad began to support them with equipment and they started to attract other funding. By 1990, the Anti-AIDS clubs had an office and paid staff.

A series of diplomatic tea-parties at the British High Commission became an unlikely catalyst of concern about HIV/AIDS in Zambia. Anne Bayley and Tony Pinching, a visiting researcher from St. Mary's hospital in London, convinced High Commissioner Sir Kelvin White and his wife Sue that AIDS presented a serious problem for Africa.[10] In June 1986, Sir Kelvin was to write the dispatch that provoked such a reaction in Britain. He and his wife also used the High Commission as a place to introduce people to each other in order to generate support for the HIV/AIDS initiatives.

In 1987 Alan Howarth, a British Psychiatrist based in Lusaka, began running a counselling programme for people with AIDS. Responsible for mental health on a country-wide basis, he sat in Dr Bayley's surgical clinic and Dr Hira's STD clinic and began to develop ways of giving counselling to people with AIDS. Essentially he established a 'snowball' training scheme, bringing together health professionals, nurses and medical assistants to spend a week discussing the basic facts about AIDS and general counselling techniques. He also encouraged trainees to discuss sex more openly, a subject he claims is still considered taboo. He then sent these groups back to work to practice what they had been taught. After a couple of months, they had another training course with more role play and real pre-test and supportive counselling. Over the next year he selected the most committed people for further training, who in turn started their own training courses. The scheme continued snowballing in this way until he had established a cadre of skilled counsellors.

[10] Interviews with Anne Bayley, Tony Newton, Sir Kelvin and Sue White.

Also in 1987, politician Rodger Chongwe, Alan Haworth, and local businessmen came together to establish an NGO that would specifically deal with AIDS called the Family Health Trust. It was clear that AIDS would have complex ramifications for families and communities. In the first place, patients would have to be cared for. Zambia's chronically under-funded health service would be largely unable to support AIDS patients in hospitals, and anyway many people preferred to be ill at home. The deaths of previously healthy adults would leave their dependants vulnerable, families may be stigmatised and so on. The Trust was established to provide counselling and home-based care for people with AIDS. Virginia O'Dell, a US nurse trained in paramedics who had moved to Zambia with her husband who was working for the French NGO *Medecines Sans Frontieres,* was appointed as a research assistant. Part of her responsibility was to recruit five Zambian nurses and paramedics to provide a home-care service in Lusaka. This home-care team received early support from WHO representative Eric van Praag. In the same year, a young Australian doctor called Ian Campbell working for the Salvation Army at Chikenkata established an AIDS Surveillance, Prevention and Care project as well as a Home-Based Care programme at the near-by Monze hospital.

Though most of these early responses were initiated by the non-government sector, they did have some high-level support. In 1988, President Kenneth Kaunda was a keynote speaker at the Stockholm 4th International AIDS Conference and spoke movingly of the death of his son from AIDS. It was a bold move and he was the first international figure to admit to being so personally affected by the illness. He then urged the international community to take the problem seriously. At the time of my fieldwork, Kaunda was under house arrest on suspicion of involvement with an attempted coup in 1997. After some negotiation with the authorities, I was allowed to interview him at his house where he told me that he had felt he "had to do something about this terrible disease" and had embraced the opportunity of publicising its effects.

Despite this high profile support, there was still a great deal of resistance to AIDS interventions. Early 'AIDS activists' described on-going battles to get senior politicians and bureaucrats to take the problem seriously and publicise the

information that was becoming available. Dr. Bayley remembers being told by one senior bureaucrat that "the President can say what he likes. You can't." Professor Pinching, who conducted early research into HIV/AIDS in Zambia, remembers encountering great resistance to publicising the problem from Zambian civil servants. Early epidemiological evidence suggested that prevalence was highest amongst relatively well-off, professional men — exactly the sort who were responsible for making policies. For more than one of the interviewees, their reluctance to publicise the issue was fuelled by personal fear for their HIV status as well as anxiety that their friends, colleagues and families would infer that they had been having extra-marital sex.

Despite these on-going battles, NGO responses to AIDS continued to mushroom. In 1989 Father Michael Kelly founded Kara Counselling, with the help of funding from the Swedish aid agency NORAD. Kara opened a drop-in centre and later started giving free testing with associated counselling. In 1990, the organisation started an AIDS education outreach programme, to factories, companies, schools and training organisations, using people who were HIV+ and who had been trained by Kara as AIDS educators.[11] In September 1990, a two-day AIDS conference for non-government organisations was held in Lusaka. In 1991, the year democratic elections put the Movement for Multi-Party for Democracy (MMD) in power, Kara established a therapeutic day-care centre in Lusaka, which offered a free course in Positive-Living, with skills training to people with AIDS.

Though these interventions were essentially indigenous, designed to respond to particular, highly contextual problems, each of these early interventions shared a similar, dialectical relationship with the international community. Each was started by people whose privileged access to international resources, relative self-confidence and personal contacts enabled them to launch organised interventions. Every intervention was built primarily around the particular skills of the charismatic individuals who started them. In the majority of cases, the interventions were

[11] Interview with Senior Medical Officer for STDs and AIDS.

started by, or had high profile support from ex-patriates. In the rest of cases, the initial leaders were particularly well-connected Zambians.

These international connections facilitated the flow of money to support organised interventions. The same connections then enabled information about them to be disseminated internationally. The British High Commissioner galvanised British attitudes to HIV/AIDS through his pungent report of June 1986. Similarly, information about Zambia's experiments in responding to HIV/AIDS were soon to receive international attention. The Chikenkata projects, for example, were supported by Actionaid, who used them as models for interventions in other countries. Dr Campbell, who subsequently became a high profile international AIDS expert for the Salvation army, also wrote up the Chikenkata experience in the *Strategies for Hope* series, which were specifically designed to provide models and ideas for interventions elsewhere (Campbell and Williams, 1990).

At the same time as having a close relationship with international organisations, these NGOs also had relatively close relationships with government. Rather than being pressure groups, these organisations were essentially 'insider' groups, working collaboratively with government. Though they may not have agreed with the government on the significance or approach to AIDS, they nonetheless worked with them. In the case of the Family Health Trust and Alan Haworth's counselling training sessions, the government provided staff and premises. There was no evidence of pressure group activity in the form of demonstrations or direct action.

Summary

Between 1981 and 1989, both Britain and Zambia developed indigenous NGO and government HIV/AIDS interventions. Relatively small communities of professionals who were alarmed by the implications AIDS had on health, advertised the problem and developed strategies for dealing with it. These networks worked relatively closely, and in both countries saw themselves as AIDS missionaries, involved in something that was frightening but also a professional and personal challenge.

The WHO was not a primary catalyst to these responses. Indeed, both Britain and Zambia developed information and interventions that were used as templates for interventions in other countries. As an organisation, WHO did not play a very active role in AIDS interventions at this, early stage of the disease. Individual WHO staff did, however, support these networks. In the case of Zambia, this support came in the form of financial and technical assistance, as well as advocacy. In Britain, this support took the form of providing evidence and information that would support indigenous networks requests for tolerant government interest in the problem.

2. 1987 – 1989: The World Health Organisation and the internationalisation of AIDS.

In many respects, HIV/AIDS had always been an international issue. Clinical and scientific information about the disease had been published internationally, international conferences had been organised and policy-makers like Donald Acheson had kept a close eye on developments from abroad. There had, however, been no formal attempts at genuine international policy co-ordination. WHO had responded relatively slowly to HIV/AIDS, only establishing a small sub-division called the Special Programme on AIDS (SPA) in 1985, and maintained a relatively low international profile on the issue. The gradual nature of its involvement was at least in part because of a lack of high-level support for the issue. Halfden Mahler, Director General of the WHO till 1987, was considered by some to have a bit of "a blind spot about AIDS", telling one of his co-workers at WHO that he regarded the problem as essentially moral. More than this, WHO did not have a large programme for sexually transmitted disease. In the early 1980s, only one person was working in this area (Berridge, 1986).

Between late 1986 and 1989, however, this changed. In 1987, every country in the world endorsed the Global AIDS Strategy, mandating the specially-formed Global Programme on AIDS (GPA) to take the lead in co-ordinating international AIDS interventions. It became the chief conduit of donor funding for HIV/AIDS and, by 1989, became the largest single WHO programme, directly funding interventions

around the world. This section of the chapter discusses how the WHO programme achieved this rapid growth and its impact on the 'AIDS missionaries'.

A. Evidence and argument

The process between WHO's initial involvement in HIV/AIDS and becoming the leading international advocate of international AIDS interventions was an iterative one. WHO staff used evidence and argument to persuade policy makers that the issue was gravely serious. This in turn led to the diversion of funds to AIDS, thereby increasing their organisational capacity and their international profile. It provides an interesting example of how a sub-group within an organisation can seize the initiative in new policy areas, thereby affecting organisational as well as policy development (Majone, 1989). It was during this period that the WHO/GPA had its most decisive influence over the development of British AIDS policies. AIDS missionaries and SPA/GPA staff kept in regular contact and were able to support each others attempts at publicising the issue and framing it within a liberal-public health paradigm.

The first breakthrough in terms of the WHO's involvement with AIDS was when the Ugandan Minister of Health conceded publicly that his country needed help with its emerging AIDS problem. In 1986, Jonathan Mann, a medically qualified epidemiologist was seconded to WHO from the Centre of Disease Control in Atlanta. In November of that year, he and Mahler gave the UN General Assembly a special briefing on AIDS, the first time that it had set aside time to discuss a health topic (Berridge, 1996). One of the most significant moves the SPA made was to gather together the epidemiological evidence from around the world to create a mathematical model, the Delphi Study, to estimate how AIDS would impact upon world health (WHO, 1989a). Though recorded incidence of AIDS was relatively low at this time, WHO argued that the problem was under-reported, and estimated that between 5 to 10 million were infected with HIV and that between 15 and 20 million would have become so by the year 2000. Current estimates of global HIV prevalence are over twice as high as these early projections (UNAIDS, 1998). They were, however, high enough to demonstrate that without intervention, AIDS was going to become a serious medical problem.

This information was then publicised in regular WHO updates. The programme worked closely with the media to generate interest in the problem. A series of press releases *In Point of Fact*, brought news about expressions of commitment from governments and UN organisations, WHO initiatives and, above all, evidence about the potential impacts of AIDS. Then, the SPA began to support various international forums for discussing and publicising the issue of HIV/AIDS.

By funding research and collating epidemiological evidence from around the world, the SPA was able to show that AIDS had been widely identified, that it could affect Africa and Asia, as well as the States, heterosexuals as well as gay men. In the early years of AIDS, many policy-makers thought that the problem would not affect them and could be safely ignored. In developing countries, books and articles had appeared arguing that AIDS was a problem only for American homosexuals and that it was a disease of the decadent West (Chiramuuta, 1987). In the West, particularly in the United States, AIDS was often seen as a problem for developing countries and 'high risk' groups. As late as 1987, US President Ronald Reagan had hardly mentioned AIDS, despite America having the largest recorded prevalence of AIDS in the world (Fowler, 1991: 250).

The primary purpose of the WHO publications was to underline the significance of the problem to all policy-makers. Information was collected, processed and publicised so as to make maximum impact. During a visit to the GPA offices in 1994, a senior economist explained to me the process by which they came up with models of the potential *economic* impact of AIDS. GPA staff gauged that politicians and policy-makers would only really take notice of HIV/AIDS it they were persuaded that it was likely to affect business and government revenues. Various ways of calculating economic impact were experimented with until the GPA team arrived at the method that produced the highest figures. The WHO/GPA staffs' explicit intention was to produce alarming statistics that could then be used to pressure governments into taking the problem seriously.

Staff at the SPA and subsequently GPA collected evidence about successful interventions from around the world. The idea was not only to scare policy-makers, but also to provide them with potential solutions. In so doing, the WHO became an increasingly important source of advice. Jonathan Mann established groups to look into particular problems as they arose, thereby creating a centre of expertise to which national policy-makers could go for help. Donald Acheson, for example, referred to WHO for advice on the knotty problem of the testing of occupations for which good health is critical: airline pilots, machine operators, train drivers and so on. At the time there was great concern about the 'dementia' that was associated with AIDS and pressure to conduct compulsory testing to screen out people who were HIV+ and therefore presumably at risk. Sir Donald asked Jonathan Mann to look into this, a research group was set up and it was found that the dementia was only associated with the very final stages of AIDS and not HIV and therefore mandatory testing would be unnecessary.

Throughout 1987, senior British health bureaucrats such as STD/AIDS specialist Peter Exon and Donald Acheson kept in regular contact with WHO staff to calculate ways they could help each other to raise the profile of the illness and fend off pressure for punitive responses. Though the DoH did not regard itself as being in any way led by the GPA, contact between the two organisations was regular and intense. Donald Acheson had close personal links with Jonathan Mann, and spoke to him frequently about ways of tackling the HIV/AIDS problem. "There was a lot of informal discussion and influence... At one time we used to have regular meetings once a month or.. two...and when Jonathan Mann came over he would normally visit... It wasn't a big conspiracy, there just weren't that many people involved... Everybody knew everybody".[12] At the time, professional exchange was actively encouraged by the DoH and people were actively encouraged to do short consultancy stints with the GPA. This level of exchange was said to have decreased since the department was "slimmed down... we just can't afford the luxury... now."[13]

[12] Interview with Senior Medical Officer for STDs and AIDS, DoH.

Despite this regular communication, none of the DoH staff interviewed regarded themselves as in any way led by the WHO. They saw their role more as guide to the WHO/GPA, based on their experience of developing AIDS policies. This self image is somewhat exaggerated. British policies had been strongly influenced by the NGO response in the US and by Holland's liberal approach to controlling HIV amongst drug-users (Fowler, 1991). What is clear, however, is that the relationship with SPA and, from 1987, GPA staff was dialectical. Staff did not feel bound by the strategy, but rather shared information to help to develop their own policies.

Britain, however, only sought advice from the WHO on specific, technical areas. In general, its policies were developed internally, after seeking information from a variety of sources, including the WHO. A common view amongst interviewees from WHO, Britain and Zambian bureaucrats was that while the WHO gave help to everyone, it was developing countries that stood to gain most from the WHO expertise. "The people who benefited the most were those for whom there was almost no possibility of having experts in anything at all. The Ministry of Health may consist of five people. The importance of WHO is inversely proportional to a country's wealth. Poor countries are able to pull up-to-date information off the shelf, correctly based in terms of science."[14]

The WHO/GPA seemed to act as nexus for formulating ideas and policies about HIV/AIDS. One of the most striking things about the British interviews was the degree of consensus that existed about HIV/AIDS and policies designed to tackle it. People from very different organisations had broadly similar views about the extent of the problem, problems that had been encountered and areas in which the policy response had been weak. To some extent, this consensus seems to have been facilitated by the regularity with which international conferences were convened, combined with the dissemination of research findings, project reports and policy statements from a wide range of organisations throughout the world. The WHO/GPA were an important facilitator of this type of exchange of ideas and

[13] Interview with Head of Population and Reproductive Health Section, ODA.

information. Though there were complaints about some of the WHO/GPA's operational procedures, all the interviewees expressed the view that the basic conceptual approach was sound. It appeared that they were able to absorb, synthesise and disseminate information about the epidemic in an effective and persuasive way.

B. Persuasion

The collection of evidence, no matter how exhaustive, is not enough in itself to influence policy. To be effective it must *persuade* influential policy-makers that the information is plausible and that it can be used as a basis for making effective policies. The WHO/GPA had no legal sanction with which to force policy-makers to comply with its agenda, so its influence was very much based on presenting itself as a neutral, accurate and practical source of information. The extent to which policy-makers did find its arguments compelling was very much a factor of its perceived legitimacy. Thus, though it had no coercive power, it was perceived as having *authority.*

i. Organisational Authority

The first facet of the WHO/GPA's authority was that the WHO was regarded as reliable, objective and technically-expert organisation. Successes with the eradication of diseases such as smallpox had confirmed its reputation as a leading health agency. The AIDS programme benefited from the esteem in which its parent organisation was held.

The perception of its authority was useful in persuading policy-makers to adopt particular responses to HIV/AIDS. All but one of the British interviewees mentioned that they used the WHO's perceived authority to back up their claims. It was thought that "people pay attention to their pronouncements" and that you "couldn't exaggerate the importance of having a WHO flag."[15] "As soon as you write WHO, somebody will sit up and take notice. That's what you're doing. You're using it cleverly to influence people who are going to know far less than

[14] Interview with former staff of the DoH.

you do, but who have more power than you."[16] Donald Acheson regularly used the WHO to back up claims on the grounds that it was authoritative. The fact that the WHO/GPA was regarded as a high-profile and authoritative voice internationally meant that members of the AIDS issue network saw it as a useful vehicle for affecting other countries approach to the problem and, ultimately, to add weight to their own approach to the problem.

However, the GPA quickly developed its own reputation for expertise. "It was the lead agency, pulling together the best minds in the world to deal with the problem."[17] The "sheer weight of organisational skill was an important complement to national AIDS programmes."[18] There was a significant degree of consensus amongst the UK respondents that the overall strategy was the right response at the time. All the respondent's thought the strategy's basic principles were sound. "It wasn't so much a liberal response, as a realistic one... the argument was successful, because it was right". If it had been a punitive response, it would have been disastrous."[19] It was felt that the having WHO approval helped to galvanise action, "has anything else been put on the world's agenda quite so quickly?"[20]

The other strength of the WHO was that it had genuinely international organisational infrastructure. As well as the headquarters in Geneva, it has offices in Washington, regional offices and, in many cases, country offices as well. It therefore had relatively easy access to other UN organisations, as well as developing countries and provided a central organisational framework for international consensus-building around the issue of HIV/AIDS. It could provide useful evidence about the global nature of the epidemic and information about the ways in which policy initiatives were impacting upon the problem. Its system of

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[15] Interview with Director of the HIV/AIDS Alliance, London.
[16] Interview with Director of Impact, London.
[17] Interview with Head of Population and Reproductive Health Section, ODA.
[18] Interview with Director of the HIV/AIDS Alliance, London.
[19] Interview with director of the Terrence Higgins Trust, London.
[20] Interview with Director of the UK NGO AIDS Consortium, London.

national programmes created "some sort of bureaucratic place...[which was] an essential first step to having some sort of response by governments."[21]

ii. Charismatic authority

Much of the GPA's influence in the early years was derived from a small group of hardworking staff who toured the world 'selling' the problem and the GPA's potential role in resolving it. In Britain, a small number of medics began to work with regularly with WHO/GPA staff in Geneva, providing each other with advice, encouragement and information. The GPA's first director, Jonathan Mann made a particular contribution in this respect and has been widely acclaimed for the energy with which he travelled the world, persuading policy-makers that HIV/AIDS was a serious problem. Four of the interviewees mentioned his charisma, "he was very charismatic. He really sold the programme and he sold the problem."[22] His charisma and personal commitment to the problem was argued to have been instrumental in generating the interest of the international community and maintaining the commitment of other AIDS workers. "There was an astonishing loyalty. None of the people I was involved with had any experience of working at international level. Jonathan Mann was very welcoming, individually kind, supportive and encouraging."[23] He was also an extremely charismatic speaker. It is said that his speech at the London Summit of Minister's of Health in 1988 'electrified' the audience, creating a real sense of shared responsibility and concern.[24]

Interviewees also expressed respect for the way in which the WHO/GPA framed the problem. They were "visionaries" who "said good things"[25] and said them well. "The cogency and eloquence with which Jonathan Mann and others framed AIDS was helpful. It made us feel more confident, because we had a framework."[26] As well as respecting various GPA staff on a personal level, it was also seen as

[21] Interview with Director of the UK AIDS Consortium, London.
[22] Interview with Senior Medical Officer for STDs and AIDS, DoH.
[23] Interview with Director of the Terrence Higgins Trust, London.
[24] Interview with Director of Impact, London.
[25] Interview with Director of Impact, London.
[26] Interview with Director of the Terrence Higgins Trust, London.

important that the GPA were respected *by others.* "They provided an absolutely essential *imprimatur* of multilateral authority."[27] Their pronouncements could be taken and used to put pressure for changes in HIV/AIDS polices.

The WHO/GPA's Global AIDS Strategy had a psychological impact on the people working in the AIDS field. AIDS work was often disheartening. Some of the founders of AIDS organisations were HIV positive themselves and some were becoming ill and dying. It was also seen as an uphill struggle to get AIDS to be taken seriously and sympathetically. "What we did look for, and what we got, was a level of leadership... a global vision of how to look forward. When you're surrounded by cruel indifference at best... it encourages people in what they were doing."[28] In moving the problem into an international arena, the GPA's strategy seemed to generate new visions and new solidarities. "There's also a, I don't know whether in trying to get NGO agendas into something like the UN, it creates, automatically a sort of solidarity amongst NGOs."[29]

iii. Constitutional authority

The final aspect of the GPA's authority was its perceived neutrality as a UN agency. This neutrality was thought to give its pronouncements weight. "Only global organisations have the impact in terms of credibility and power of influencing national government."[30] A UN organisation can provide a high profile, prestigious international platform. This was thought to be a significant factor in persuading politicians to sign the Global AIDS Strategy, whether they were convinced by its contents or not. "The way in which the UN works is peer pressure. When you get together a bunch of ministers who turn up because of diplomatic considerations, considerations about how they look on an international stage.. you can .. supply sufficient peer pressure for people to sign up to things which if it was just within a national context they wouldn't dream of doing."[31] The same NGO worker remembered seeing a harassed health minister at the 40th

[27] Interview with Director of the HIV/AIDS Alliance, London.
[28] Interview with Director of the Terrence Higgins Trust, London.
[29] Interview with Interview with Director of UK NGO AIDS Consortium.
[30] Interview with Specialist in Sexual Health Programme, ODA.
[31] Interview with Director of Impact, London.

World Health Assembly, when the Global AIDS Strategy was first endorsed, anxiously ringing up his staff to find out their policy on AIDS. Disappointed by the answer, he shouted, "Then get one."

As a UN organisation, the WHO could also provide a neutral forum in which to discuss the problem of HIV and AIDS. "The GMC provided a useful mechanism for articulating what the demands are, to achieve consensus.[32] A similar sentiment was expressed by the ODA. "As a UN organisation, the GPA is constitutionally obliged to include a range of nations on its GMC... In terms of partnership and... 'ownership' of an issue, it is far better to have a forum where problems can be articulated clearly and at a global context".[33] National-level bureaucrats began to sit on the GPA's various board, as will be discussed in more detail below. The GMC was composed of government representatives from various countries and intergovernmental organisations and non-governmental organisations were granted observer status (WHO/GPA, 1996: 61).

Governments became committed to sending representatives to international meetings in which the problems of HIV/AIDS were discussed. In Britain, Donald Acheson became very closely involved with the GPA. The UK has a historically close relationship with the WHO and maintains a strong official presence there. The CMO is responsible for representing the UK government at the WHO in the Minister's absence, which was most of the time and was present at all the WHO meetings on HIV/AIDS. The representatives of the UK's Department of Health and Overseas Development agency felt that lobbying the WHO/GPA was an important part of their role. Both organisations tried to influence the GPA formally, through public statements and their positions on the General Management Committee, and more informally.

In addition to bring experts together, the WHO/GPA served as a means of providing leverage to national lobbyists interested in 'selling' the HIV/AIDS problem to policy-makers. Five of the UK organisations interviewed mentioned

[32] Interview with Director of Impact, London.

that the WHO was a useful source of information and statistics. The fact that they provided information about the extent of the problem *internationally* was regarded as important in underlining the potential threat to Britain. In many ways the interviewees appeared to approach the WHO/GPA and the Global AIDS Strategies as discerning consumers, using them to substantiate their arguments and to apply pressure to individuals or organisations they sought to influence. On a day-to-day level, this came from WHO/GPA pronouncements. All but one of the respondents thought that at the time WHO were held in respect by the international community and that their pronouncements carried weight. They could therefore cite the WHO when making requests for extra funding or lobbying for particular policy innovations. Once governments had signed the resolutions, for whatever political or diplomatic reason, national and international pressure groups were in a stronger position to lobby governments to abide by its terms.

In other circumstances, AIDS workers would collaborate with the GPA to react to what they perceived as retrograde national developments. In 1987, shortly before the London World Summit of Ministers of Health a small group of UK civil servants met GPA staff to discuss how best to fend off a potentially stigmatising change in testing procedures which was being pushed forward by the then health minister Virginia Bottomley. The group agreed to exploit the London Summit, duly opening it with a speech by Jonathan Mann emphasising Britain's exemplary stand on HIV and human rights. Later, civil servants explained to the minister that, in the circumstances, it would embarrass Britain internationally to change Britain's health policies. The existing, policy remained unaltered. On another occasion, the GPA, DoH and representatives from Australia and New Zealand met up to discuss how best to deal with a campaign in the Murdoch press which stated that the link between HIV and AIDS was unproved.[34]

3. The international mobilisation

Between 1985 and 1987, the WHO helped to generate more and more interest in AIDS. This in turn, lead to greater investment in HIV/AIDS. The signing of

[33] Interview with Specialist in Sexual Health Programme, ODA.

Global AIDS Strategy in 1987 gave official endorsement to the Global Programme on AIDS (GPA), the WHO programme for implementing the strategy. The GPA was to be attached directly to the office of the Director-General of WHO and operated within WHO's policy and programme framework. The GPA was organised into five programme areas, which directly echoed WHO's organisational structure:

1. Programme Direction: the Office of the Director
2. National AIDS Programme Support
3. Scientific and Technical Units
    - Biomedical Research
    - Epidemiological Support and Research
    - Health Promotion
    - Social and Behavioural Research
    - Surveillance, Forecasting and Impact Assessment
4. Management, Administration and Information
5. Regional and Inter-country Support.

In addition to this, a three-tiered advisory structure was created to provide GPA with guidance. The first structure was an external management review called the GPA Management Committee, or GMC. The GMC was to act as an advisory body to the Director-General of WHO, making recommendations on the programme of activities and budget of GPA, its financing and management, progress towards achievement of its objectives, and ways of improving GPA co-ordination with relevant organisations.

The GMC was to represent the interests and responsibilities of WHO's external partners collaborating with WHO in the implementation of the Global AIDS Strategy. Membership of the board included:

1. Representatives of donors of undesignated funding for the programme

[34] Interview with DoH participant at the meeting.

2. Representatives of two governments from each of WHO's six regions
3. Representatives of the six major inter-governmental organisations contributing to the implementation of the Global AIDS Strategy, as well as the chairman of the Global Commission on AIDS.[35]

Other intergovernmental organisations and non-governmental organisations deeply involved in the Global AIDS Strategy were, on request, granted observer status.[36]

The second structure was the Global Commission on AIDS (GCA), which gave broad policy, technical and operational guidance. This was responsible for advising the Director General on scientific priorities for the GPA research agenda. It reviewed global HIV/AIDS trends and developments, provided expert guidance on GPA's global activities, advise on the establishment of scientific working groups and review and evaluated GPA activities from a scientific, technical and operational viewpoint. The final structure consisted of a series of steering committees. Detailed scientific guidance for priority components of the GPA research agenda were led by specially-formed steering committees, brought together by the GPA's Director General.

Support for the Global AIDS Strategy came predominantly from official development assistance (ODA), which transfers funds from the industrialised donor countries to international agencies, governmental and non-governmental AIDS programmes in developing countries. Official Development assistance is defined as "aid administered with the promotion of economic development and welfare as the main objective; it is concessional in character and contains a grant of at least 25%" (Laws; 1996: 375). The table below shows contributions to the Global AIDS Strategy from 1986 to 1993, the only years for which full sets of figures are available. 'Bilateral' funding refers to direct grants from a donor agency to a government project or programme. Multi-lateral funding refers to undesignated funding to an international agency. During this period, the majority of multi-lateral funding for AIDS interventions was paid to the WHO/GPA. Multi-bilateral

[35] UNDP, UNICEF, UNFPA, UNESCO, World Bank and the EC

funding refers to money spent to an international organisation for designated projects.

After a rapid rise from 1897 to 1990, funding began to decline. Though the figures for 1993 appear to rise again, this increase is attributable to the fact that because of the time the survey was done they include multiple-year grants extending beyond the end of 1993. Elsewhere this has been adjusted for (Laws, 1996).

Table 5.1: Total Contributions to the Global AIDS Strategy 1986-1993 ($US million)

Channel	1986	1987	1988	1989	1990	1991	1992	1993	Total
Bilateral	0.11	15.3	39.40	64.8	98.9	125.01	129.8	146.49	619.81
Multilat/bilat		13.21	30.69	30.16	31.58	23.53	26.69	31.11	186.97
Multilateral		30.26	63.42	65.58	81.73	75.0	75.5	76.69	471.18
Total	0.11	58.77	133.51	160.54	212.21	223.54	231.99	257.29	1,277.96

Note: Figures for 1993 provisional as of August 1995. These amounts include multiple-year grants extending beyond 1993.

Source: Laws, 1996

After the endorsement of the Global AIDS Strategy in 1987, the WHO/GPA grew rapidly. By November 1988, the GPA was actively collaborating with 140 countries to form national AIDS programmes (WHO, 1988c). Within two years, it was the largest programme in the WHO, an unprecedented growth rate within the organisation (WHO, 1996: 2). The number of WHO/GPA staff grew from just two in 1986 to 400 in early 1990 and financial resources at GPA's disposal increased from US$1 million to over US$80 million in 1990 (WHO, 1996: 2).

Although nominally a global strategy, the GPA's express priority was giving advice and technical assistance to countries with limited financial and technical resources. "Assistance was especially provided to countries requesting help in carrying out

[36] WHO/GPA/DIR/88.7; 1988: 11

rapid assessments of the epidemiology of HIV in their national setting to and to improve diagnostic, laboratory and blood screening capacity" (WHO, 1997: 3). The WHO had acknowledged expertise within this technical realm and provided much needed resources and experience.

In parallel with this technical assistance, between 1987 and 1989 the GPA concentrated on getting basic technical information to as broad a range as possible to scientists, public health officials and policy-makers (WHO, 1987). Here too, the emphasis was on the redistribution of knowledge from North to South. Basic information which was "freely available in industrial countries" should be made accessible to low income countries (WHO, 1987: 54). In January 1988, the GPA launched the World AIDS Series with the aim of providing "state-of-the art information to all" (*ibid*). They produced materials for the general public as well as technical resources such as manuals and protocols.

At the same time, WHO continued its international forums, which aimed to help the co-ordination of AIDS interventions worldwide. World AIDS Days and AIDS summits were the most high-profile of these efforts, but the WHO also organised international conferences and meetings between private pharmaceutical companies and non-government organisations.

WHO has described the period between 1987 and 1993 as the 'institutionalization' phase of the international response to HIV/AIDS (WHO, 1997). Not only was the GPA was integrated into the administrative structure of WHO and established an extensive programme of assistance to (mostly low-income) member states. The unprecedented in-flow of donor resources to WHO/GPA supported a much more direct managerial involvement in low-income countries. The National AIDS Programme Support (NPS) section was established to promote and support national governments to develop, implement, monitor and evaluate "strong and comprehensive national AIDS programme, in conformity with the global strategy for the prevention and control of AIDS" (WHO, 1988c: 5). WHO established National AIDS Control Programmes (NACPs) within Ministries of Health to "develop policies, identify strategies and co-ordinate national activities" (WHO,

1988c: 5). In many cases, the start-up costs of these NACPs were funded directly by the WHO/GPA itself, who also provided staff. Three WHO staff were normally appointed: a technical officer, who was responsible for managing the programme, an information and education expert and an epidemiologist. These staff took on a direct and active role in administering and implementing AIDS interventions in low-income countries.

Summary

Britain and Zambia's responses to HIV/AIDS in the early years of the epidemic were broadly comparable. In both countries, small groups of doctors noticed unusual cases, initiated small research programmes and exchanged information internationally with their peers. Alongside this, small interest groups began launching initiatives by or on behalf of people affected by HIV/AIDS. Together, these groups pressured governments into organising formal responses to HIV/AIDS. Both countries launched AIDS information campaigns in early 1987, before the Global AIDS Strategy was endorsed. The only significant difference was in the relationship between these interest groups and government and the international community. In Britain, AIDS interest groups retained some form of 'outsider' lobbying role on government, alongside closer collaborative work with government agencies. In Zambia, AIDS organisations at this time were all essentially 'insider' groups. Though the individuals who started them may have differed with government on the significance of the problem, from the start they operated within a government framework, effectively providing health services. They were also more dependent on funding from external bodies such as Norad. The WHO did not play a very significant part during the early stages of these responses. In both countries, support such as it was came from interested individuals such as the SPA director Jonathan Mann and the Zambia representative Eric van Praag.

From late 1986 the WHO began to take a more active role in disseminating information about HIV/AIDS and generating a consensus greater consensus about appropriate responses to it. The WHO/GPA had four effects at this stage of the

epidemic. In the first place, it used epidemiological evidence to establish the view that HIV/AIDS was a serious, trans-national problem, rather than being the parochial concern of some 'high-risk' groups. In the second place, it amplified existing pressure from national interest groups. Thirdly, it helped to mobilise international aid funding. Finally, it provided a bureaucratic space from which to launch international interventions.

During this period, the greatest impact of the WHO appears to have been the influence of persuasive ideas. The strategy had no coercive effect and its economic impact at this stage was limited. The Strategy embodied a liberal-medical way of conceptualising a problem that stressed its significance while presenting a set of solutions to minimise its effects.

Expert opinion from a number of other countries was used to formulate these policies and information was being disseminated through conferences and international journals. But by modelling itself as the key international body with the expertise and infrastructure to tackle HIV/AIDS, the GPA became an important vehicle for explaining and justifying policy innovations. International epidemiological evidence collected and disseminated by the WHO, combined with their clear policy statements, became part of the arsenal used by senior health professionals' to explain, justify and develop policy.

There is some evidence that the more international the work of the relevant health professional became, the less they were guided by national-level pressures for punitive approaches to HIV/AIDS. One former GPA worker explained "The attacks I heard most often were not ... about it being too liberal. Because these are the circles of sort of over-educated international bureaucrats ... the debate was in a liberal paradigm... only the most radical dissidents talked about things outside those parameters."[37] Policies were developed according to a liberal, public health attitude to disease, which ultimately gave individuals responsibility for containing risk.

[37] Interview with Director of the HIV/AIDS Alliance.

However, while the ideas and values of these bureaucrats were undoubtedly influential, it was the fact that they operated within an organisational framework that *had the means* to launch policy initiatives, that ultimately directed funding towards them in the early years of the international response.

Chapter six

Organising and implementing the 'global' strategy

Introduction

The previous chapter analysed the agenda-setting and formulation stages of HIV/AIDS policies and the evolution of the Global AIDS Strategy from the working papers of a small sub-division of WHO to the focus of a significant transfer of donor funding from North to South. This chapter discusses the WHO/GPA's impact upon AIDS policy development from 1989 to 1995, when the GPA was closed down. Until 1989, responses to HIV/AIDS and the relationship between national organisations and the WHO/GPA were broadly comparable, albeit on different scales. Local doctors and non-government groups campaigned to draw attention to the emerging problem. Staff at the WHO/GPA supported their lobbying to government and provided technical support and authoritative information about specific issues surrounding HIV/AIDS. From 1989, however, when the very considerable resources generated by the WHO/GPA began to be channelled directly into AIDS interventions, these relationships quickly diverged, a trend that was in large part a reflection of the countries' different status as funder and fundee of WHO programmes.

This chapter is divided into two main sections covering the development HIV/AIDS policies in Britain and Zambia respectively. Each analyses the main development in HIV/AIDS policies over the period, before addressing the three research questions; to what extent were the objectives of the Strategy achieved, in what ways did the WHO/GPA's Strategy impact upon national AIDS policies; and what were the main factors that influenced this impact?

British HIV/AIDS policies had two distinct dimensions, domestic and international. Domestic policies, relating to the prevention of HIV infection and treatment and services for UK residents affected by AIDS, were largely developed by the Department of Health, though other government departments including the Home Office and the Ministry of Education were also affected by AIDS issues.

International AIDS policies were largely the responsibility of the Overseas Development Agency (ODA), and were predominantly concerned with controlling HIV infection in developing countries.

Without having a central National AIDS Programme, the British government launched a strong, if somewhat inconsistent response to AIDS. The medical/public health core of the AIDS issue network gradually consolidated a central power to define policy, launching relatively well-funded interventions that reflected medical preferences. There were, however, challenges to the dominant, public health approach to AIDS, particularly in non-health policy areas such as the prison service and education. The WHO/GPA's influence over the development of domestic policy was relatively limited, confined to advice, technical support and consensus-building through its international meetings and conferences. It had a more significant impact upon the way that Britain spent its overseas aid, though this influence declined over time.

In Zambia, the WHO/GPA had a more direct influence on policy development. In 1989, the WHO/GPA began funding, and administering a 'National' AIDS programme. Its staff managed the programme and its offices were housed in the Zambian WHO headquarters. The early, largely indigenous organisational responses became institutionalised within this WHO/GPA umbrella programme and became increasingly dependent on donor funding. Over time, however, various factors served to undermine AIDS interventions. In 1991, a government less sympathetic to the liberal premises enshrined in the National AIDS Programme was voted into power. Internal and external factors led to a decline in donor funding to the AIDS programme and the AIDS programme began to falter.

1. The development of AIDS policies in Britain.

A. Policy development: normalisation and bureaucratisation

The previous chapter discussed the early 'war-time' responses to HIV/AIDS, as a relatively diverse issue network of 'AIDS missionaries' launched *ad hoc* responses and campaigned to develop a liberal consensus around the issue. These early

responses were largely voluntaristic in nature, catalysed by committed individuals. From 1987, however, there began a gradual process of what Berridge (1996) has termed the "normalisation... professionalisation and institutionalisation" (Berridge, 1996: 155). of the issue. HIV/AIDS became to be seen less as an emergency epidemic and more as chronic illness which affected relatively small sections of the population. In the process, the AIDS issue network settled into relatively distinct 'inner' and 'outer' circles. The central core of medics, public health experts and politicians – the traditional members of Britain's health policy community – consolidated a central power to define policy. AIDS policy development during this time reflects most clearly the preferences of this group.

A number of factors assisted the gradual 'normalisation' of HIV/AIDS as a policy issue. The first was the Cox report published in 1989, which revised existing projections of HIV prevalence downwards, from 10,000 new cases in 1992 to 2,000 – 5,000 (HMSO, 1989). Effectively, the report removed the threat of an immediate heterosexual epidemic. Bio-medical advances also helped to redefine AIDS within a 'chronic disease' model, rather than an emergency epidemic. In 1987, the UK granted approval for the use of azidothymidine (AZT) as a palliative medicine. The average life expectancy for people with AIDS was being prolonged, if only relatively briefly, but it provided hope for longer-term remedies. People with the HIV virus, medics and AIDS activists alike embraced the idea that AIDS was not necessarily the decisive fatal disease it had seemed.

As AIDS became 'normalised', it was became increasingly institutionalised within NHS structures. Increased funding saw a rapid expansion of paid posts in health authorities. The AIDS Unit in the DHSS grew quickly, and by early 1987 had 34 full-time staff. The Expert Advisory Group on AIDS (EAGA) which had been dominated by a relatively small group of 'AIDS missionaries', became more heavily represented by civil servants and its proactive and defining role in policy development began to decline (see Berridge, 1996: Chapter Eight). Within government, official committees proliferated. Soon, seven other official advisory groupings were supplying guidance on AIDS-related issues such as its impact on the NHS and HIV/AIDS and drug misuse. At the end of 1987, EAGA's 'small

central group was nearly doubled in size and its numerous sub-groups reorganised into just four core issues: monitoring and surveillance, blood-screening, psychiatry and health care workers.

Outside government, what had been fairly *ad hoc* funding became regularised within a framework of grants to health and local authorities. AIDS organisations and services proliferated, and so too did costs. In 1987-88, £25.1 million was spent on AIDS-related health services. By 1990-91, this had risen to $125 million (Berridge, 1996: 166). Funding began to be targeted direct to local authorities, mainly for services such as specialist social work posts and home-based care to people with AIDS. Increasingly, service responses shifted away from the specialist towards dominant models of service provision. Throughout the late '80s and early '90s, for example, AIDS policies began shifting treatment and services away from hospitals towards home-based care. This shift towards community care was very much in-line with the departmental agenda for other vulnerable groups including drug-users and the mentally ill. It was seen as more cost-effective than hospital-based interventions, and more patient-friendly. Health, housing and social services were being more closely integrated with a view to keeping patients at home, rather than hospital. In 1990, these trends were formalised by the Community Care Act. AIDS had moved from being a specialist issue, to one that could be tackled within dominant policy models (see Berridge, 1996: Chapter Seven).

The gradual 'normalisation' and 'institutionalisation' of AIDS was equally apparent in health education and research as well as the non-government sector. The MRC integrated its AIDS research into its normal funding mechanisms. The Health Education Authority (HEA) moved away from high profile, mass media AIDS awareness campaigns into more wide-ranging community-based education. During the late 1980s, AIDS education had been vertical programme within the HEA that absorbed £10 million out of the Health Education's £24 million budget (Berridge, 1996: 201). By 1989, this was seen as disproportionate to the scale of the problem and AIDS education was reorganised into a more broad-ranging sexual health programme. Though funding remained high, it was spread horizontally and could be used for other programmes. Voluntary organisations were also rapidly

institutionalised. In the early 1990s, nearly 80% of overall funding for AIDS organisations came from statutory sources (Berridge, 1996: 176). Generalist organisations such as the Citizens Advice Bureau and Dr. Barnardo's began to provide AIDS-related services in addition to the first, specialist NGOs.

As AIDS became institutionalised within the health service, the relative influence of non-government groups began to decline. During the early emergency responses, AIDS missionaries had value to senior-policy in their unique insight into and experience of the emerging problem. By the late eighties, however, their comparative advantage was being eroded, as the government were becoming more directly involved with HIV/AIDS service provision. Though organisations like the THT, Landmark and the Lighthouse Trust continued to receive funding from government, they increasingly found themselves sidelined from important policy decisions.[1] In part, this was due to internal organisational problems. The THT, for example, found the leap from a small, gay pressure group to a major service provider created ideological and personality clashes (see Berridge, 1996). Yet while it was conceded that the government had some legitimate doubts about pouring funds into small, untested organisations, it was also thought that civil servants had revealed a deep-seated anxiety about channelling substantial funding into gay-based organisations.[2]

Instead, AIDS policy development from the late eighties appears to confirm the centrality of medical interests in British health policy. The resolutions of two contentious issues – that of anonymous screening and that of infected health workers – are used as illustration. For Berridge (1996: 213), the issue of anonymous screening is a "case study in the power of public-health interests, in alliance with sympathetic politicians, to define what were considered to be appropriate measures to examine the epidemic." In 1987, the Social Services Committee on HIV/AIDS firmly rejected the use of anonymous screening as an epidemiological tool in favour of voluntary named testing. The committee were

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[1] Taped interview with director of Terrence Higgins Trust.

[2] Taped interview with director of Terrence Higgins Trust.

sympathetic to AIDS missionary Professor Kennedy's view that "screening must confer some benefit upon the patient, albeit indirectly, and also that testing will not provide the answers to the right questions" (HMSO, 1987: xi). They accepted arguments that anonymous testing was a crude tool by which to monitor prevalence in the general population and that it raised difficult questions about patients giving informed consent. There was also no political support for a course of action that could be seen as intrusive and unethical.

Soon, however, senior medics began to question this judgement. In 1988, a Public Health Laboratory Service report recommended that anonymous testing should be introduced. In *The Lancet*, a group of past and current presidents of the Royal College of Physicians supported the idea and though the Royal College of Midwives objected strongly to the moves on ethical grounds, the BMA also came out in favour of it. In 1988, Kenneth Clarke, the new Secretary of State for the recently independent Department of Health decided to over-rule the Social Services Committee decision and to introduce screening (Berridge, 1996: 212).

For Day and Klein (1989), no policy development so clearly reflected the value systems of the medical profession than the contentious issue of infected health workers. Late in 1985, EAGA set up a sub-group to look at the issue. The subject caused great debate, centring around whether doctors should be allowed to continue working, whether they should wear gloves and whether they should be allowed to conduct invasive techniques. Shortly afterwards, however, the *News of the World* threatened to publish names of two infected workers. Doctors with HIV, it was argued, were knowingly risking the lives of patients. In some cases, their employees were aware of their status and were thus failing in their duty of care to the public. Given this failing, it was in the public interest to publicise doctors' positive HIV status, so that patients could at least choose whether they wished to undergo invasive surgery. The CMO invited Jonathan Mann from the GPA to an emergency meeting to respond to this development.[3] Subsequently, the Department of Health sought and won a permanent injunction against publication,

[3] Interview with Senior Medical Officer, DoH.

arguing that the risk to patients was negligible. The issue did not die down, however and continued to attract vituperative articles in the press. Both the BMA and EAGA set up committees to look into the issue and both advocated a voluntary code of practice that put the onus on the professionalism of workers. Infected workers should seek (specialist) advice on whether they posed a threat to their patients and make a professional judgement as to whether it was safe for them to continue working. Policy was formed on the balance of risks against individual rights, but the weighting of that balance was firmly on the side of doctors' rights to continue practising rather than on patients' rights.

Though medics retained a central power to define policy within the health sector, outside the sector, policies were less influenced by the liberal 'consensus' on HIV/AIDS. The prison service for example deflected Department of Health calls to allow condoms and/or clean syringes or sterilising equipment to be made available in prison. Their argument was that it would condone illegal behaviour. Homosexual sex, they argued, was illegal in a public place. Prisons were public and sex was therefore illegal. Equally, they refused to allow needle exchanges, despite the fact that they had been introduced outside prisons in 1989 which could equally be said to be condoning illegal behaviour. The prison health service was outside the National Health Service and came under the Home Office umbrella. Doctors did not have secure and regularised access within the policy process, and their influence was correspondingly weaker.

B. Achieving the aims

The Global AIDS Strategy had three core objectives: the prevention of HIV infection, reducing the personal and social impacts of AIDS and unifying national and international interventions. There was a remarkable consensus amongst the interviewees about the strengths and weaknesses of responses to HIV/AIDS in Britain. All the interviewees thought that Britain had organised a strong and well-resourced response to HIV/AIDS and that it had done well compared with other industrialised countries. Annual incidence of HIV in Britain was thought to have peaked as early as 1985 and with an HIV prevalence of only 0.087 *per cent* of the population aged 15-49, Britain has a lower prevalence of HIV than the US (0.514)

and many of its European neighbours. Amongst others, France, Germany, Belgium, Denmark, Ireland, Italy and Spain have higher rates of HIV prevalence (UNAIDS, 1996). The respondents agreed that the issue had been well publicised by the government and that there was a high level of awareness about the disease.

The only complaint about the government's response in terms of controlling transmission of the HIV virus was that it had not dealt well with what one respondent termed the 'chaotic fringe'.[4] The approach was based on giving people information and encouraging them to minimise risky behaviours. In practice, however, people do not have equal capacity to control the degree of risk to which they exposed themselves. Prison inmates were officially denied access to condoms or clean syringes/sterilising equipment. More often, however, differences in the extent to which people could control risk depended on their material, political and human resources. The main body of the gay 'community', for example, were politically organised and relatively well-resourced politically and economically. They had therefore been effective in organising themselves to demand services, to exchange information and to modify risk behaviours.[5] This was not the case of intravenous drug-users and, particularly, the homeless, including the mentally ill. These groups had found it relatively difficult to organise themselves either individually or collectively.

All the respondents agreed that, during the period in question, the government had provided a good range of services for people with AIDS. The issue had attracted an enviable pool of resources and, in the main, policy had been developed in a liberal and non-judgemental way that was in accordance with the overall aims of the Global AIDS Strategy. Public records support this unanimous consensus amongst the interviewees that the British government had been committed to HIV/AIDS and had channelled significant resources into the area. Ring-fenced budgets for HIV and AIDS interventions in each of the health authorities rose from £61.2 million in 1988/89 to £121 million in 1989/90 (HMSO, 1992). In terms of

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[4] Taped interview with director of the London Lighthouse.

[5] Taped interview with director of the UK NGO Consortium for the Third World.

research funding, the government spent a total of £129.4 million on HIV/AIDS research between 1989 and 1995, compared with £90.3 million on cancer and £43.9 million on heart disease over the same period (Hansard, 1996: 3/37). A survey of overseas development assistance to HIV/AIDS interventions puts Britain as the third largest individual donor, after the US and Sweden. Britain spent a total of $US85.26 million in support of the Global AIDS Strategy between 1987 and 1993, in addition to the contributions made, indirectly, through the European Union (Laws, 1996).

One of the ways in which the WHO/GPA determined that the social impact of HIV/AIDS could be ameliorated was to create a non-discriminatory legal framework. Though the UK has no specifically anti-discriminatory legislation with regard to HIV/AIDS, the interviewees praised the then government for having avoided the worst excesses of actively discriminatory legislation. It had no travel restrictions, HIV/AIDS was not a notifiable disease and testing was voluntary and anonymous. The establishment of needle exchanges for intravenous drug-users was cited as an example of effective, liberal policy-making that had significantly helped the control of HIV.[6] It was, however, considered a weakness that there was no effective anti-discriminatory legislation[7] and Britain did introduce one piece of specifically discriminatory legislation. In 1985, various sections of the Public Health (Disease Control) Act were amended to include AIDS (WHO, 1994: Haigh and Harris, 1995). These provisions related to compulsory medical examination – if it was in either the person's interest or that of their family – and compulsory removal and detention to hospital if proper precautions to prevent spread could not or were not being taken. Two other sections concerned the handling of the bodies of people with AIDS. This legislation was not, however, regarded as a significant threat to people with AIDS. It has only been used once and was immediately rejected by the magistrate. It was regarded as a piece of 'panic legislation' from

[6] Taped interview with director of Immunity.

[7] Taped interview with directors of Terrence Higgins Trust and International HIV/AIDS Alliance.

1985, which had no effective force and was designed only for the most extreme circumstances.[8]

Though the interviewees broadly approved of the government's approach to HIV/AIDS and discrimination, there were a number of criticisms about legislation during the period that was not directly to do with HIV/AIDS, but which made implementing HIV/AIDS control policies more difficult. For one of the interviewees, MP's refusal to lower the age of consent for homosexuals to sixteen publicly condoned discrimination on the grounds of sexuality.[9] In 1988, the Conservative government introduced the notorious Section 28 of the 1988 Local Government Act, which banned the 'promotion' of homosexuality by local authorities. For some of the interviewees, this circumscribed teachers' ability to give a rounded AIDS education in schools.[10]

C. The WHO/GPA Strategy's impact

The WHO/GPA had relatively limited direct or formal impact on British AIDS organisations. None of the representatives of domestic AIDS organisation interviewed felt bound by the terms of the Global AIDS Strategy, or regarded the WHO/GPA's pronouncements as other than a useful source of information. It did, however, retain two areas of influence. The first was as a centre of discussion and information. Representatives from a broad range of AIDS organisations continued to attend its international conferences, to sit on its management committees and exchange information with its staff. Its second area of impact was in Britain's international AIDS policy. The ODA channelled a significant proportion of its overseas spending on HIV/AIDS through WHO/GPA AIDS programmes, though spending through this channel declined over time. International NGOs used WHO conferences and the international endorsement of the Global AIDS Strategy as a source of political leverage against the governments of other countries.

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[8] Taped interview with director of Immunity.

[9] Taped interviews with directors of Immunity and Terrence Higgins Trust.

[10] Taped interviews with Terrence Higgins Trust and Immunity.

i. The WHO/GPA and domestic polices

After the initial 'war-time' response, when WHO/GPA staff played a key role in persuading policy-makers of the issue's significance, its influence on HIV/AIDS policies within Britain began to decline. Signing the 'Global' Strategy was not seen as having an ultimately binding effect on policies. Given that Britain was a high-income country that had developed some expertise in HIV/AIDS policy, the GPA did not seek to establish a National AIDS Programme in Britain. British organisations regarded themselves, and were regarded by the WHO/GPA as competent to develop its own policies. None of the representatives of AIDS organisations interviewed regarded themselves as having been directly led or co-ordinated by the WHO/GPA. Neither did it fund any British interventions. None of the interviewees consciously sought to design their programmes so as to be in alignment with the WHO/GPA, and representatives of the DoH, ODA and NGOs expressed surprise at the idea in interviews. Representatives of the DoH did not see themselves as being in anyway 'led' by the WHO/GPA. "We wished to align our policies with them... but certainly, there was absolutely no sense of getting their approval." Elsewhere, it was said, "we weren't trying to get anything from it [meetings with the GPA]. We were putting in. We saw ourselves and were received, I think, ... as very much in the lead on developing policy on HIV and AIDS"[11]

Similarly, domestic AIDS NGOs had a limited involvement with the WHO. WHA Resolution 42/8 acknowledged the role of NGOs in the struggle against AIDS. "The GPA's Director's office works closely with the WHO Programme for External Co-ordination (COR) on communication links for a full, active and regular dialogue between GPA and its external partners, to promote the involvement of non-governmental organisations in AIDS prevention and control activities and to ensure international co-ordination in conformity with the Global AIDS Strategy" (WHO/GPA, 1988: 6). Despite this, British NGOs had a limited contact with the

[11] Taped interview with programme officer at the DoH.

WHO. Other than some small grants for exchange programmes,[12] the UK NGOs that provided services in Britain received no funding from WHO/GPA and did not regard them as being particularly relevant to them. The WHO/GPA and the Global AIDS Strategy were seen as being for low-income countries.

Though the direct and formal impact of the GPA on UK AIDS policies was limited, there was regular contact between staff at the GPA and AIDS organisations. Barbara Kelly, the chief civil servant involved with AIDS at the ODA became chair of the GPA management committee. So to did Donald Acheson, who was also on the executive board of the WHO. Some of the original 'AIDS missionaries' such as Tony Newton and Brian Gazzard were invited on WHO-funded consultancies to low-income countries. DoH staff continued professional exchanges at the WHO/GPA head-quarters in Geneva. All the interviewees had been to international fora organised by the GPA and four regularly attended the six-monthly General Management Committee meetings.[13] These international conferences were seen as very important. At the time, "international co-operation was really the fifth arm of our strategy".[14] They were seen as important networking opportunities, "because there were a lot of people there who also see it as a key networking activity."[15]

ii. The WHO/GPA and overseas policy

Though the WHO/GPA had a relatively limited contact with domestic AIDS organisations, both government and non-government, it had a more direct role in the allocation of Britain's official development assistance. Between 1987 and 1993, the Overseas Development Agency (ODA) channelled over 60 *per cent* of its HIV/AIDS funding directly through WHO/GPA programmes in undesignated

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[12] Taped interviews with representatives of the London Lighthouse, the UK Consortium for the Third World and the Terrence Higgins Trust.

[13] Taped interviews with Directors of Immunity the UK Consortium; DoH staff member; ODA officer.

[14] DoH former staff member

[15] Taped interview with representative of UK NGO Consortium.

funding. A further 12 *per cent* was for designated projects to be administered by the WHO/GPA. The table below shows Britain's overseas development assistance for AIDS interventions by funding channel. Here again however, the WHO/GPA's influence declined over time. The GPA was seen as a short-term measure for distributing assistance, but in the longer term the ODA administered more and more of its aid programmes directly.

For the ODA, the emerging problem of HIV/AIDS highlighted the issue of whether donor funding was best spent through the 'bilateral' agreements between donor and recipient governments or through multi-lateral agencies like the WHO/GPA. In general, the perceived advantage of multi-lateral agencies is that they can provide expertise, broad access and some economies of scale. Their disadvantage, however, is that once donors give funding to them, they lose control over how their money is spent.[16] A compromise is to give a multi-lateral agency 'designated' funding for a named project. This type of funding is termed multi/bi-lateral aid.

Table 6.1: Britain's contributions in support of the Global AIDS Strategy (US$ million)

	1987	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**	**Total**
Multi-lateral	5.19	8.22	7.27	8.47	8.27	7.83	8.4	53.65
Multi-Bilateral	0	2.5	1.5	0	3.13	3.42	0	10.55
Bilateral	0	0	4.2	3.4	3.9	1.9	7.76[17]	21.16
Total	*5.19*	*10.72*	*12.97*	*11.87*	*15.3*	*13.15*	*19.16*	*85.36*

Source: Laws, 1996

The ODA regarded the WHO/GPA as having some "comparative advantage" over bilateral projects. In addition to their specialist knowledge, they had a pre-existing system of regional and national offices, and could thereby "get to places individual

[16] Interview with former ODA programme director.

[17] Estimate based upon figures supplied for fiscal year reported on in survey.

donors may never reach."[18] Budget cuts during the 1980s had meant that the ODA had reduced the number of countries they gave money to directly and the WHO/GPA were a way of filling the gap. It was also thought that multilateral organisations enjoyed a more stable relationship with recipient countries. "Even when we're talking to a recipient government, we're only one donor. That relationship is an on-going one. They may like us one day and not the next."[19]

Even within the realm of overseas development assistance, however, the ODA did not regard themselves as being led by WHO. Staff described being aware of a trade-off between the comparative advantage offered by targeting funds through multi-lateral organisations and the inevitable consequence that they would have less direct influence over the way things were done. As time went on, staff at the ODA began to believe that the WHO/GPA were expanding into areas in which it had no 'comparative advantage'. As knowledge of HIV/AIDS expanded, a consensus emerged that vulnerability to HIV and AIDS was dependent on wider development issues, such as people's general physical well-being, their education and freedom of choice. ODA staff objected to the way the GPA was moving into development areas such as human rights, gender issues and poverty alleviation that they felt were the concern of other UN agencies. This was perceived as inefficient; "it is far better to have fairly tight-knit organisations, which have a tight mandate. It's dangerous to keep expanding the mandate."[20]

The ODA tried to compensate for their lack of direct influence by making "impact at a number of levels from the top-down to field level." One of their main objectives was to make sure that "the programme maintains its strategic focus, prioritised to represent value for money." ODA staff would join the GPA's appraisal or monitoring missions. Their field officers would go to co-ordinating meetings with UN agencies and generally take any opportunity to put the ODA

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[18] Taped interview with former ODA programme Director.

[19] Taped interview with former ODA programme Director.

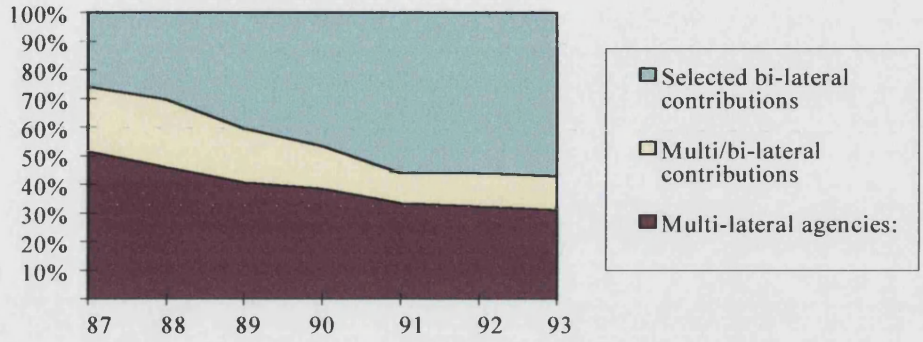
[20] Taped interview with ODA programme Director.

message across.[21] ODA representatives tried to ensure that their bilateral programmes complemented existing programmes, but their aim was to augment perceived gaps in GPA programmes rather than allow themselves to be 'co-ordinated' by WHO. Gradually, ODA funding via the WHO fell as a proportion of overall funding on HIV/AIDS interventions abroad. The WHO/GPA were seen as a short-term means of allocating funds quickly. In the longer term, they preferred the closer, bilateral arrangements that gave them maximum 'control' over spending. The WHO/GPA were seen as entering into non-health areas in which had no expertise.

This ambivalence about multi-lateral funding *via* the WHO/GPA was not particular to ODA staff. Donor representatives of other funding agencies were also suspicious not just of the WHO/GPA in particular but of multi-lateral funding in general. The figure below shows the breakdown of overall donor funding to the Global AIDS Strategy by funding channel. The proportion of undesignated funding *via* the WHO fell steadily over these six years, from over fifty *per cent*, to just over 30 *per cent*. This finding corroborates interview evidence from the ODA and funding agencies in Zambia, which suggests that the WHO/GPA was seen as a short-term means for establishing AIDS interventions quickly. In the longer term, donors preferred to fund bi-lateral projects, over which they had greater control and which were more tightly focused.

[21] Taped interview with ODA programme Director.

Figure 6.1: Breakdown of contributions to the Global AIDS Strategy by funding channel



Source: Laws, 1996

Not all the respondents, however, shared the ODA view that the WHO/GPA had expanded its remit too widely. The issue raised the most divergent views in what were otherwise a broadly consensual set of interviews. Overall, interviewees regarded the WHO/GPA's liberal, public health approach as the 'right way' to deal with the issue, and it was thought that the international community, motivated by the WHO/GPA, had responded relatively quickly to a serious and complex problem. On the question of how broad the WHO/GPA's remit should have been, however, ODA and NGO staff's opinion contrasted. All the NGO representatives expressed the view that the WHO/GPA had been too focused on health interventions and were slow in addressing wider issues such as poverty and human rights. "There was a reaction against huge, specialised AIDS programmes."[22] It was felt the GPA did not deal with small community groups effectively[23] and that they were not addressing important issues such as education; "they were interested in amelioration, rather than anything to do with social change."[24]

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[22] Taped interview with director of International HIV/AIDS Alliance.

[23] Taped interview with directors of International HIV/AIDS Alliance and UK NGO Consortium.

[24] Taped interview with director of the London Lighthouse.

UK NGOs who worked in developing countries had more direct experience of the WHO/GPA yet here again they did not regard themselves as being in anyway led by them. Indeed, the chair of the UK NGO Consortium described her members as being "up in arms" about ultimately abortive attempts by WHO to try to direct their activities. They regarded their own operational experience of HIV/AIDS interventions and working with local-level organisations as in many ways superior to that of the WHO/GPA.[25] Essentially, they were seen as an *inter-governmental* organisation, that had a limited understanding and expertise in their own, non-government arena. They were, however, perceived as having a technical expertise that would be useful to governments in low-income countries and, importantly, as a high-profile inter-governmental organisation, they could provide a platform for putting political pressure on governments. The British NGO movement, led by the UK AIDS Consortium, continued to lobby the WHO/GPA in various forums, seeing them as a "key path" to putting pressure on governments for policy reforms. NGOs took an organised and active role in lobbying the GPA, "Oh, endlessly. We did it all the time."[26] On one occasion, NGOs objected in a complete bloc to the GPA's candidate for a GPA/NGO liaison position. Another candidate was found. In 1990, UK NGOs boycotted an NGO summit organised by the GPA in San Francisco, objecting to the US government's stance on immigration for people with HIV/AIDS. "What people wanted to do was to change the entry restrictions. But at that point, the key path for doing that was seen to be GPA."[27] This lobbying was thought to have a knock-on effect. The following year, the GPA itself boycotted an international conference on AIDS hosted by the Thai government, which itself had travel restrictions, a blow to the success of the conference and to the diplomatic standing of the Thai government.

D. The key determinants of the WHO/GPA Strategy's influence

Various factors constrained the WHO/GPA Strategy's influence over policy development. The first was policy timing. By the time the WHO Strategy was

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[25] Interviews with directors of International HIV/AIDS Alliance and UK NGO Consortium.

[26] Interview with Director of UK NGO AIDS Consortium.

[27] Interview with Director of UK NGO AIDS Consortium.

operational, Britain had already felt the impact of HIV/AIDS and had begun to evolve its own policies. Department of Health representatives were clear that they were contributing to the WHO/GPA's understanding of the problem, rather than gaining from it. Related to this, was the relative difference in resources between the WHO/GPA and the Department of Health. Until 1989, the WHO/GPA was a relatively small department within WHO. Its main activities were pooling and disseminating extant research and forming work groups to look into specific policy areas. In comparison, the DoH had considerable resources to develop its own policies and an elaborate institutional infrastructure with which to implement them. Even after 1989, Britain did not receive, or expect to receive, financial or technical support from the WHO/GPA; "though the programme was supposed to be global, in practice it was very much centred on developing countries".[28]

A second determinant was the WHO/GPA's lack of jurisdiction of policy making. One of the areas in which Britain diverged most dramatically from the ideals embodied in the Global AIDS Strategy was its legislation. Britain enacted some actively discriminatory legislation (pertaining to the compulsory detention of people infected by the HIV virus) and failed to develop specifically anti-discriminatory laws. The WHO/GPA had no jurisdiction over UK policies and could not compel it to change its legislation. Changes in statutory legislation were more affected by internal institutional and political policy constraints than Britain's formal undertaking to establish a non-discriminatory legal framework. The failure to introduce anti-discriminatory legislation was partly influenced by Britain's legal system, which has an historic reliance on case law. Drafting and endorsing primary legislation in Britain is difficult and time-consuming compared with other European countries, preferring things to be kept on a voluntary footing where possible. "So you could argue that though our policies and strategies follow the global programme, unlike some countries, many countries in fact, we didn't enshrine them in legislation."[29] To illustrate the point, by 1994, Britain had made only eight separate statutory innovations relating to HIV/AIDS. France, however, had

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[28] Taped interview with Senior Medical Officer at the DoH.

[29] Interview with Senior Medical Officer at the DoH

eighty-one separate orders, circulars, decrees and notices including legislation that actively prohibited discrimination against people on the grounds of the HIV status (WHO, 1994b).

A more significant underlying constraint to creating an anti-discriminatory legal framework along the lines endorsed in the strategy, was an undercurrent of hostility to the liberal assumptions underpinning the public health approach to HIV/AIDS. 'Section 28' banning the 'promotion of homosexuality' by Local Authorities, for example, was introduced at a time when the DoH was actively trying to promote sex education, especially regarding homosexual sex. The development of HIV/AIDS policies in Britain involved an on-going tension between the cogency and urgency of the liberal 'public health' view of HIV/AIDS and its undoubted political sensitivity. The 'public health' view prevailed where medical experts had regular, institutionalised access to policy-makers. Retreats into conservatism occurred when policies where developed in those parts of government that had less sustained contact with these types of liberal/medical arguments such as the Home Office (supplying condoms to convicts and section 28).

In chapter four, I discussed the way in which Britain's health policy community was under assault from the Thatcher government for perceived inefficiencies brought upon by the dominance of health professionals within the health policy environment. Despite this assault, the long-term development of HIV/AIDS policies indicates that the medical/public health core of the AIDS issue network retained a central power to define policy, developing well-resourced services for people with HIV/AIDS that were based on liberal, public health principles. Over time, these services became less specialised in nature, and were increasingly institutionalised within existing paradigms of health care and social services.

The medical consensus on HIV/AIDS did not, however, extend throughout British policy and there is evidence of a clear break in the influence of this public health approach outside the health sector. The inconsistency in approach between different sectors indicates the influence of the policy community in the development

of health policies. The liberal approach to AIDS was not a generic 'medical' or 'moral' value, it was an argument put forward by specific sub-groups of public health bureaucrats and senior doctors who were closely involved in formulating government policy. Liberal policy choices were political and highly contested, they were not adopted because the government and public had been persuaded by international 'epistemic' liberal public health arguments in any general or permanent way. Many people in government, within civil society and in the health profession itself were resistant to the way AIDS policies were developed.

Health policy, however, was largely informed by the liberal-medical values of a relatively small number of senior health bureaucrats. Together, medics, bureaucrats and senior politicians were able to push through a series of liberal HIV/AIDS interventions *in spite* of political resistance. Interviewees from a wide cross-spectrum of AIDS organisations agreed that Britain's response to AIDS had been generous in scale and liberal in approach, compared with both overall government policy of the time and other industrialised countries. The WHO/GPA's most significant influence stemmed from its ability to support this community with advice, technical information and means of applying political pressure on the government.

2. Zambia and the global programme

If, after 1989, the WHO/GPA's relationship with British AIDS organisations was largely based on attendance at conferences, information-sharing, personal contacts and professional exchange, in Zambia the WHO/GPA took on a direct operational role, funding, administering and co-ordinating official responses to HIV/AIDS. This section of the chapter discusses the development of AIDS policy in Zambia from 1989 to 1995 when the GPA was disbanded. It discusses the establishment of the WHO/GPA AIDS programme and the creation of what I will term a 'donor-dependent network', an interdependent network of weakly-accountable government actors, health bureaucrats, donor agencies and large NGOs. Each of these groups had some ability to influence policy, but none had a decisive influence over its direction. The result was policy interventions that were relatively bureaucratic and ineffective. The consensus amongst interviewees was that Zambia had been relatively successful in organising a centralised, high profile AIDS programme. Where it had been less successful, however, was impacting upon rates of transmission and in attitudes towards HIV/AIDS.

A. Policy development

Up until 1989 doctors developed and co-ordinated Zambia's government responses to HIV/AIDS. Prompted by the alarming results of the CDC teams sentinel testing in 1985, the government established an AIDS Surveillance Committee that met once a month and became the primary forum for a small group of medical AIDS 'missionaries' to pool information about HIV/AIDS and to plan interventions, such as the 1987 poster campaign. As time went on, however, the donor community began to take a more active interest in low-income countries' responses to HIV/AIDS. Late in 1988, a donor-initiated review of the Surveillance Committee criticised its medical-focus, and suggested that its membership should be expanded to include specialists from other disciplines such as social science and the law.[30] The review recommended that a specially formed secretariat should act as an AIDS steering committee, developing strategies and advising government on issues

[30] Interview with former member of the AIDS Surveillance Committee.

surrounding HIV/AIDS. The original Surveillance Committee was duly disbanded, but the multi-sectoral committee that was supposed to replace it was never established. "It was a bad time to be starting something new. Zambia was in difficulties. People were not on the committee full time and it was operationally difficult. The committee was never appointed."[31] Instead, in 1989 the WHO established a central AIDS programme in its offices in Lusaka. The 'Zambian National AIDS Prevention and Control Programme' (NAPCP) was initiated the WHO/GPA and funded by donors through bi-lateral grants and the GPA's own sources of multi-lateral funding. Nominally under the auspices of the Ministry of Health, the government's main contribution to the programme was to re-deploy Ministry of Health staff to the new programme.[32] In a resource-poor policy context, the WHO/GPA-sponsored NAPCP became the focus of Zambian AIDS interventions. The circumstance of its creation, however, is still a source of rancour amongst some of the senior local doctors who duly lost their pro-active policy role. "The NAPCP took over the function of the National AIDS Surveillance Committee... Basically, they had all the money and they were organised. Our idea just fizzled out."[33]

In many ways, Zambia's NAPCP was typical of the national AIDS programmes the GPA was establishing around the world and bore the strong imprint of the WHO. Even the name NAPCP was a generic title applied to all WHO's AIDS programmes. The NAPCP had five programme areas. Programme Management; IEC and Counselling; Laboratory/Blood Transfusion; STD care, and Epidemiology. Thus, it reflected the WHO's philosophy, organisational structure and technical expertise. Effectively it represented an administrative 'ideal type' of state-sponsored, liberal public health interventions. It had a central management base and provided technical support with which to monitor the epidemic's development and to ensure a safe blood supply. Its information and education department operated on the liberal principle that the way to control the epidemic

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[31] Interview with former member of the AIDS Surveillance Committee.

[32] Interview with NAPCP Technical Officer (programme manager).

[33] Interview with former member of the AIDS Surveillance Committee.

was to inform the public of health risks. It was then up to the individual to ensure that they took the appropriate steps to avoid infection. Staffing at the NAPCP was also strongly influenced by the WHO/GPA. Three of the programme's most senior, full-time executive staff were expatriates from WHO: an epidemiologist, an education and information specialist and a technical officer, who oversaw the day-to-day management and administration of the programme (Thuo, 1998: 31). These three categories of senior staff were typical of WHO/GPA national AIDS programmes throughout the developing world.

The programme did, however, also reflect indigenous developments in AIDS interventions and several of the original 'AIDS missionaries' began to work from within the NAPCP structure. Successive programme managers □ Dr. Himonga, Dr. Msiska and the current manager Dr Moses Sichone □ were all local doctors who moved over to the NAPCP from the Ministry of Health's University Teaching Hospital. Alan Haworth's counselling training for health professionals continued throughout the period and got funding directly from the WHO in Geneva. The training service was housed at the WHO offices and got funding, advice and administrative support from them. Though called NAPCP employees, Haworth and his colleagues, were not full-time and were paid for by the Ministry of Health (Thuo, 1998). The programme also differed from generic WHO/GPA programmes in that Zambia's indigenous AIDS NGOs were brought in under the NAPCP umbrella and began getting funding *via* the WHO/GPA. The Family Health Trust expanded, providing AIDS education as well as clinical outreach services to people with AIDS. It still provides all official home-based care for the Lusaka-urban area and operates from the government-owned central hospital and the hospital automatically refers its HIV+ patients to the trust. Home-based care quickly became seen as one of Zambia's most successful, indigenous responses to AIDS and was heavily promoted by the NAPCP. It was perceived to be an advantage to allow terminally ill patients to be with their families rather than alone in hospital. It also cost less than equivalent hospital treatment (NASTL, 1994a). Similar home based care services mushroomed throughout the country, and by 1993, there were 52 such services run by either NGOs or the government (NASTL, 1994a). There were, however, on-going problems about funding these relatively expensive clinical

out-reach initiatives. Though home-based care was cheaper than hospital, it still stretched Zambia's limited health budget. By 1994 it was officially acknowledged that only 33 of these programmes were actually operational (NASTL, 1994a: 10). One government home based care team I visited in the large, rural district Mazabuka had no access to vehicles. The team of nursing staff could therefore only visit people within walking distance of their office.

Organisationally the NAPCP occupied a complex and ambiguous position. It was designed as a vertically integrated, specialist AIDS programme. Effectively, it represented an ensemble of donor-sponsored AIDS service providers, supported by government staff seconded to the programme. Officially, it came under the umbrella of the Ministry of Health but in practice, it operated largely independently of it. To some extent, the creation of a separate administrative space served to distance AIDS interventions from the state. Up until 1989, for example, multilateral funding for AIDS interventions were paid to the Zambian Ministry of Health *via* a WHO Imprest Account. In 1989, financial services were 'streamlined' by establishing a separate NAPCP bank account disbursed and administered by the WHO/GPA's technical officer (Thuo, 1998). Zambia's 'national' programme was funded by donors and had no clear mandate to develop government AIDS policies.

The WHO/GPA's office in Zambia adopted a proactive approach to attracting and co-ordinating donor interventions. Just as on the international level the WHO/GPA seized the initiative in promoting HIV/AIDS as an issue, so did the GPA's Lusaka office at the national level. The table below shows the donor funds that were mobilised by the WHO/GPA for the NAPCP, and indicates the speed with which funding flooded into an almost entirely new programme. The donations shown include both multi-lateral contributions (undesignated funding to the WHO/GPA) and multi-bilateral grants (ear-marked funding disbursed *via* the WHO/GPA. Given that the Government of Zambia's entire budget for health was only around $6 million at this time (UNZA 1998), the vertical AIDS programme represented a significant new source of funding for health interventions.

Table 6.2: Funds mobilised by WHO/GPA for Zambia's NAPCP (US$).

Biennium	Amount (US$)
1989-90	3,828,293
1990-91	3,364,581
1992-93	2,410,916
1994-95	967,603
Total	**10,571,393**

Source: Thuo, 1998

The rapid inflow of donor funds is illustrative of the success with which the WHO/GPA had publicised the AIDS issue and galvanised responses to it. In part because of the WHO's efforts on the international stage, donor agencies like Britain's ODA had become sensitised to the problem of AIDS in developing countries. They were therefore willing to channel funding through a recognised programme that had been authorised by a respected international agency like the WHO. Similarly, the Norwegian development agency Norad originally channelled two-thirds of its funding for AIDS interventions through the NAPCP.[34]

Total funding to the programme, however, quickly began to fall. Part of the decline was due to factors that were external to the Zambian programme. During 1991 there was a marked increase in HIV prevalence in South East Asian countries, and the WHO/GPA trust funds were being shared amongst a greater number of countries. The decrease in spending for 1992/3 partially reflects this sudden constraint on funding for AIDS interventions. In 1994-1995, contributions fell again. By this time, the closure of the GPA had already been announced, causing donors to delay funding while they waited to see how the AIDS

[34] Interview with Norad health and population specialist, Lusaka.

programme would develop.[35] There was, therefore less money available to implement the programme as it was originally conceived.

However, declines in funding patterns were also the result of changes in policy at donor agency's headquarters. The ODA's Zambian office, for example, went some way towards developing a £1.5 million proposal for HIV/AIDS care, which was to last five years from 1994 and was designed to develop cost effective models of service delivery and strengthen district capacity to provide such services (GRZ/ODA, 1994). The programme was, however, cancelled shortly before it was due to start because of a change in the ODA's policy on health interventions. In essence, the ODA decided that supporting sector-wide reform would be more beneficial to the country than a vertical programme, such as the proposed HIV/AIDS Health Care Programme.[36]

Bilateral agency's funding policies were also influenced by changes in their relationship to successive governments. In 1991, the Movement for Multi-Party Democracy (MMD) were voted into power. The newly elected president, Frederick Chiluba, is a Christian fundamentalist, and declared the country a Christian state in 1993. In common with the increasing number of fundamentalist Christians in Zambia, Chiluba is thought to see AIDS as an essentially moral problem, a judgement from God for immoral behaviour. Chiluba has never gone officially 'on-record' as being against liberal AIDS interventions. During his time in office, however, the President has only made three public statements about AIDS. In the most recent, in June 1997, he said that what was needed was 'a cure, not condoms' (*Times of Zambia*, 1998: 1). In more private forums, Chiluba has made it clear that he disapproves of the liberal assumption that AIDS should be prevented by promoting condoms, which he regards as tantamount to promoting carnal sin. In 1993, a director of Zambian national television authorised a transmission of a series of HIV/AIDS adverts that were broadcast three or four times a night. Chiluba denounced the campaign at an Evangelical meeting, asking

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[35] Interview with Norad representative, Lusaka.

[36] Interview with DfID Health and Population Officer, Lusaka.

the congregation what was happening to Zambia when you could switch on the television and see this sort of campaign. Shortly afterwards, the director was sacked, only six weeks after taking on the post.[37]

There were also on-going doubts within the AIDS issue network about the effectiveness of a vertical AIDS programme that was not integrated with other health initiatives or with the activities of other ministries. In 1992, after lobbying from within the Ministry of Health, the national STD and leprosy programmes were integrated with the AIDS programme and NAPCP was renamed the National AIDS/STDs/TB and Leprosy programme (NASTL, 1994b: 2). In April 1993, a National Consensus Workshop on HIV/AIDS agreed that the AIDS programme was too medically focused and that the Second Medium Term Plan should develop a more multi-sectoral approach to HIV/AIDS (Thuo, 1998). Zambia's official responses to AIDS had come almost exclusively from the Ministry of Health and NASTL, and no other ministry had developed any significant policies on HIV/AIDS. NASTL asked every ministry to appoint an AIDS 'focal point person' was then sent on a week long residential training course funded by NASTL (NASTL, 1994b). NASTL was to provide logistical and technical support to focal point people in order to stimulate broad-ranging AIDS policy interventions across the public sector.

The effect of the initiative, however, was limited. In the first place, many of the appointed focal point people had a low status within their ministry and did not have the authority to make radical changes to policy.[38] In the second place, the 'training' had been rather didactic awareness training, rather than an attempt to stimulate creative responses to AIDS.[39] Thus, once they returned to their work, AIDS focal point people tended to carry on doing what the NAPCP had been doing – put up posters and distribute condoms within their ministries. They did not incorporate an AIDS dimension into their day-to-day activities, and the new 'multi-

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[37] Taped interview with anonymous doctor at the University Teach Hospital, Lusaka.

[38] Interview with former Minister.

[39] Interview with project director within the NAPCP.

sectoral' approach never materialised. By the end of 1994, a US-sponsored consultant was seconded to NASTL to develop a more process-oriented approach to stimulating official responses. The aim was to work with focal point people to identify their ministry's comparative advantage in terms of HIV/AIDS and to develop their own initiatives.[40] Her appointment and approach created some tension with NASTL. The GPA were thought to be suspicious of what they regarded as a vague and unquantifiable intervention. By the end of 1995, however, 14 of 95 ministries had begun to develop at least a draft AIDS strategy and some had begun to implement AIDS specific policies. In 1997, the Ministry of Communications and Transport, allowed condoms to be sold in Post Offices, which has helped distribute condoms more widely, especially in rural areas. The same year the Ministry of Science and Technology began an HIV/AIDS curriculum to run in parallel with vocational training.

Despite these slow advances, by 1994/1995 NASTL was in difficulties. By that time it was not only clear that the GPA were shutting down, but there was a consensus developing that the Zambian health sector required wholesale reform. Donors began withhold funding from the AIDS programme as they waited to see how the programme would develop. Other donors, like the ODA, began redirecting funds towards sector-wide health reforms and away from vertically integrated programmes like NASTL. Though still in operation, it had less funding than had been anticipated at its inception and its services were being stretched to the limit. Finally, at the end of 1995, the WHO/GPA was shut down. Staff continued to work at the NASTL offices, but morale was low and programmes curtailed.

B. Achieving the aims

There was a general consensus amongst the respondents that Zambia's response to AIDS had been disappointing. Though the majority of the interviewees regarded the creation of the NAPCP as an useful step in that it created a high-profile administrative space from which to co-ordinate AIDS interventions, it had limited

[40] Interview with former member of NAPCP staff

success in achieving the overall objectives of the strategy: preventing the transmission of HIV, alleviating the personal and social impacts of HIV infection and AIDS and mobilising and unifying national and international efforts. The current estimate of adult prevalence of HIV in Zambia is 19.9 *per cent*, making it one of the worst affected countries in the world. Only Botswana and Zimbabwe are thought to have a higher prevalence of HIV (UNAIDS, 1996). Neighbouring Uganda has made substantial inroads into controlling the spread of the disease (UNAIDS, 1999). The table below shows the breakdown by district.

Table 6.2: Zambian Adult Prevalence Estimates of HIV by Province, 1997 (Ages 15 and older)

Province	Adult (%)	Urban (%)	Rural (%)
Central	20.8	29.8	16.7
Copperbelt	23.4	25.3	15.7
Eastern	14.7	31.7	12.7
Luapula	22.8	28.9	21.1
Lusaka	26.5	29.9	13.4
Northern	18.9	29.8	16.8
North Western	11	23.6	8.7
Southern	16.8	31.7	12.1
Western	17.5	24.5	16.1
Nat. Total.	**19.9**	**27.9**	**14.8**

Source: Ministry of Health/Central Board of Health, 1997

There was a broad consensus amongst the interviewees that though the majority of people had heard of AIDS; this knowledge has not translated into changes in behaviour, a perception that is backed up by various Knowledge, Attitude, Practice and Belief (KAPB) studies (Chela, 1992; Malibata, 1994). In one survey, 35% of respondents had had a sexually-transmitted disease in the previous year and only 34% reported using condoms, despite the fact that 99% were aware that AIDS was spread by sexual transmission (Gaisie, Cross and Nsemukila, 1993). Dry sex, which

greatly increases the risk of vaginal or penile abrasions during sex, is widely practised in Zambia and significantly increases the risk of infection from HIV (Malibata, 1994. Similarly, the widespread practice of sexual cleansing, whereby a widow is ritually cleansed of her dead husband's spirit by having sex with a close relative of her dead husband, represents a threat of infection if her husband died of a sexually-transmitted disease (Abrahamsen, 1997).

Zambia's AIDS prevention interventions were predicated on the assumption that greater understanding of the disease would eventually lead to behaviour change. Like Britain, however, the weakness of the approach was that not everyone enjoys equal ability to control the degree of risk to which they are exposed. The range of choices available to people are constrained by the economic, social and political resources available to them and to power relations within their society. Women in Zambia are rarely able to refuse unsafe sex due to their subordinate position toward their husband or partner. Condoms are widely associated with prostitutes and a woman who requests their partner to use one is often assumed to be either promiscuous or accusing their husband of infidelity (Abrahamsen, 1997). Women who depend on men economically or for the social status they gain from being married, are reluctant to jeopardise their relationships by insisting on monogamy and/or the use of condoms during sex (Abrahamsen, 1997). Equally sex work or offering 'sexual favours' in return for gifts or services may be an integral part of poor womens' survival strategies. As one NGO worker explained, women are often faced with the choice of having unsafe sex, thereby running the risk of dying in several years, or refusing it and face the more immediate threat of starving.

The second objective of the Strategy was to reduce the personal and social impacts of the disease. One of the clearest themes to emerge from the interviews was that Zambia's response to AIDS had been bureaucratic and that there was nothing 'on the ground' for people affected by AIDS. There was an overwhelming consensus amongst the interviewees that the burden of care for people with AIDS has fallen on households and, increasingly, community-based organisations such as church groups. Within households, AIDS affects women disproportionately. Women have to care for the ill and develop survival strategies as household incomes fall

(Abrahamsen, 1997). Given the lack of hospital places, in general people are left to die at home, often without the most basic facilities or palliative care. Discrimination against people with HIV/AIDS was widespread, sustaining denial of the problem.

Just under a quarter of the respondents regarded 'red tape' and obstructive bureaucracy as major obstacle to implementing effective education campaigns and health services. Policy responses were 'all on paper', with little 'on the ground'. Two explanations for this tendency emerged from the interviews. For the majority of local staff, the bureaucracy was symptomatic of a shortage of funds for the on-going costs of AIDS interventions. Donors had created an administrative space to co-ordinate interventions, but had not given enough money to run services effectively. Attempts to alleviate the personal and social impact of HIV/AIDS were constrained by the shortage of resources for day-to-day care and treatment. Though there is a policy of treating people with AIDS-related illnesses, for example, in practice doctors are only able to treat the most common AIDS-related illnesses such as malaria and TB. Because of the shortage of resources for diagnostic tests, even at the central hospital, diagnoses are usually made by clinical observation.[41] In rural areas, which are less accessible to both government and non-government health services, treatment is even harder to obtain. Shortage of funds had also affected the administration of the AIDS programme. Though the WHO/GPA set up a sentinel system that provides data for estimating the extent of HIV infection, financial constraints have meant that 1994 is the only year in which data is available from each of the sentinel sites (MoH, 1997). NASTL staff complained that though donors had offered to pay for the production of educational leaflets and posters, they had no money to actually disseminate the educational material in their possession. When I visited the NASTL, one side of the office was lined with fading boxes of posters that were waiting for funds to be released for their distribution. Both government and NGOs provide home-based care to people with AIDS, but services are focused in urban areas and can provide only limited support to primary care-givers.

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[41] Interview with medical specialist University Teaching Hospital, Lusaka.

Other explanations for the bureaucratic and ineffective response focused around low-key but nonetheless effective resistance from Zambian officials. The majority of the representatives of AIDS organisations I interviewed shared the perception that influential members of the government were hostile to AIDS interventions. These representatives saw a clear distinction between the official Ministry of Health view – that HIV/AIDS was a serious health and development problem – and that of senior civil servants and members of government, who thought the problem was essentially a moral one. In Zambia's somewhat tense political climate this has made many AIDS activists reluctant to be too proactive about AIDS interventions. In interviews, representatives of donor, government and NGO organisations said that they had been actively discouraged from promoting AIDS as an issue by members of government. It was also thought that many politicians, including Ministers of Health, had deliberately underplayed the issue, for fear of losing their jobs. This political hostility has been evident from the very earliest stages of AIDS and was thought to have significantly undermined indigenous and donor-funded AIDS interventions in the country.

The 'bureaucratic' and top-down criticisms were not just levelled at the official government responses. It also applied to the large, NASTL-sponsored NGOs. Staff from smaller NGOs and community-based organisations thought that the NGOs provided expensive, localised services in urban areas. In the first place, AIDS NGOs tended to congregate in the main urban areas to maintain close relationships with their funders. This had the effect of concentrating services in small areas, often actually duplicating services. Both Kara and the Family Health Trust offer counselling training in the Lusaka urban area, for example. Donor accounting procedures meant that NGOs had to recruit trained staff and divert its energy into putting in proposals. They maintained large, well-equipped offices, with support staff, and 24-hour security, all of which diverted resources away from their intended recipients. The director of one major NGO "[has] the feeling that the main beneficiaries of [the NGO] were the employees... I end up spending my time and effort keeping them employed and I'm not happy with the work they're doing is making the impact it should. You end up with massive NGOs, you end up

with administrators, cleaners, guards. The overheads. You wonder if the beneficiaries are getting the value out of it. I don't see why I should be keeping these sixty people fed. If I was really convinced they were making a huge impact... But when I had just two others, we were doing more work."

The same director was cynical about the motives of many of the more senior NGO staff. "There's a group of professional NGO people who match the professional diplomat people, and to be honest some of them don't care. They're all accountants and auditors who are anxious to get rid of some of this money. It's an industry. But the things is, a lot of the money doesn't reach down." It was also thought that donor's accounting procedures favoured large NGOs against smaller community groups, who were rarely able to fulfil their administrative requirements. The director of one major NGO thought that part of the problem was that donor's put a crudely conceived emphasis on 'transparency', only funding one-off, tangible projects such as expensive residential conferences and workshops. Obtaining money for on-going projects such as a series of non-residential seminars was almost impossible. He suspected that the problem was that donors found it administratively too difficult to monitor and co-ordinate many small projects, so instead focused on funding capital costs and training. This view was confirmed in interviews with staff from NASTL and UNICEF. Funding disparate community-based innovations was expensive and time-consuming and it was therefore preferable to fund a small number of core NGOs.

There was a consensus amongst the interviewees that discrimination against people with AIDS was widespread, despite the high prevalence of AIDS. In one survey, 26% of the respondents believed people with AIDS should be isolated (Baggaley *et al*, 1994). In resolution WHA42.34, the government of Zambia undertook to avoid legal provisions that may impede the implementation of the strategy and to work in collaboration with non-governmental organisations to overcome discriminatory attitudes. Though Zambia has no legislation that specifically discriminates against people with AIDS, neither does it have legislation that

specifically prohibits discrimination on the grounds of their HIV status.[42] All the interviewees from AIDS organisations accepted the WHO argument that discrimination against people with AIDS was unfair in itself and unhelpful in controlling the spread of the disease. Despite this, no case of unfair dismissal or discrimination has ever been brought before a court. Interviewees perceived the main obstacle to creating a less discriminatory environment to be the absence of clear anti-discriminatory legislation. Three interviewees from Civil Society Organisations said that this absence made it difficult for them to protect their members. A trade union representative said that they had little confidence that their cause would be supported if it were taken to a tribunal or court and they could not advice their members to risk the adverse publicity. A director of the patients' organisation the Network of People Living With AIDS argued that people affected by HIV/AIDS are still unconfident that their rights would be protected by the courts. Despite the high levels of prevalence of AIDS, relatively few people have 'gone public' about their HIV status.

The problems surrounding issues of discrimination were compounded by the lack of accessible platforms to air issues surrounding discrimination. For the majority of the population, the official state legal system is inaccessible. State courts only operate in major urban areas, and are expensive and extremely slow. In the absence of specific, anti-discriminatory legislation, one lawyer I interviewed began to prepare a claim for compensation from an employer who had dismissed his HIV+ client on the grounds that the dismissal had contravened his client's *constitutional* protection from discrimination on the grounds of social status. Sadly, however, the legal process took so long that the client died before the case came to court. In the absence of an accessible state legal system, the only legal forums effectively available to most Zambians are traditional and local courts, presided over by traditional leaders. Zambia has a two-tiered legal system of statutory, and customary and traditional law. Where there is no clear statutory law – for example concerning non-discrimination and HIV/AIDS – traditional leaders

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[42] In 1997, the Federation of Zambian Employers and the International Labour Organisation agreed a policy of non-discrimination in the workplace, though this is not legally enforceable.

refer to customary laws when making judgements in local courts. Rulings at traditional courts have often worked counter to NAPCP policy of non-discrimination against people with HIV/AIDS (Scott, 1998).

The final objective of the Global AIDS Strategy was to co-ordinate national and international efforts to control HIV/AIDS. In setting up the NAPCP, the WHO/GPA ensured that official national and international AIDS interventions were relatively closely integrated. The organisational structure of the NAPCP was such that all the AIDS organisations that fell within its umbrella were in regular contact with one and other. In interviews, all representatives of AIDS organisations had received some form of financial and technical support from the WHO/GPA. If they did not receive regular grants, NGOs received help with transport costs and sponsorship to attend conferences. Similarly, all had attended meetings and conferences organised by them. The WHO/GPA sponsored four main AIDS policy forums. Internally, 'NAPCP' staff met once a month for AIDS management meetings. The WHO also held quarterly meetings for UN agencies and bilateral donors at the WHO offices in Lusaka, which aimed to promote and co-ordinate donor AIDS interventions. Once a year, the NAPCP ran a National AIDS Conference, which was attended in the main by NAPCP staff, NGOs and donor agencies. From 1991, the NAPCP organised an annual meeting for provincial and district AIDS co-ordinators. Finally, there was a regularised exchange of staff between the organisations. NAPCP staff sat on the governing boards of the major NGOs such as the Family Health Trust, and Tasintha. In the case of Tasintha – an NGO that provides support to sex workers – the presence of an NAPCP staff-member on the board was a condition of donor funding.[43] Similarly, staff from donor organisations were seconded to the NAPCP. In 1994, the US-funded NGO the Moorhouse Project, for example, sponsored a consultant Robie Siamwiza to assist policy development within the AIDS programme. The WHO/GPA were also considered essential in brokering relationships between donors and NGOs. In many cases, donors funded NGOs *via* the AIDS

[43] Interview with Director of Tasintha.

programme. NAPCP support was also essential to get direct funding from donors. Without NAPCP, and hence WHO/GPA approval, donors would not fund NGOs.

By these means, donor agencies, Ministry of Health staff, the large AIDS NGOs and the WHO/GPA kept in regular contact. Within this group, there was a significant degree of consensus about the significance of AIDS as a policy issue and appropriate responses to it. All the representatives of these organisations approved of the general thrust of the NAPCP's approach in interviews. They agreed that AIDS was a serious problem and that the best way of tackling it was through education programmes and adopting a policy of tolerance and non-discrimination so as to bring the problem into the open.

Outside this core group of organisations, however, contacts with the NAPCP were more irregular. The forums, organised by the NAPCP and funded by donors, were attended by staff from the NAPCP, the MoH, donor agencies and NGOs. Meetings were not attended by community groups, religious organisations, unions or any other of Zambia's indigenous civil society organisations (Thuo, 1998). Chiluba's attitude to AIDS and the relatively poor performance of the multi-sectoral initiative substantiate interviewees' claims that the message about AIDS had 'not got through' to people outside this relatively small group of AIDS and/or development organisations.

A report produced by the Law Development Commission provides a vivid example of how inconsistently the liberal AIDS message has been integrated into policy-making bodies outside a relatively small group of health and AIDS organisations. In 1997, the Law Development Commission was approached by an expatriate staff member of NASTL and asked to prepare a report on HIV/AIDS and the law. Zambia has no legislation that prevents discrimination one the grounds of HIV status, and no cases have been brought before the courts. The commission did not endorse the liberal line on AIDS, instead approaching the problem from the point of view of its threat to "the structure of families and society as a whole" (Law Development Commission, 1997: 1). It made a series of robust recommendations, which included "making fornication a felony or misdemeanour punishable by a term

of imprisonment" (Law Development Commission, 1997; 8). Other recommendations were to make a negative testing for HIV an official requirement before people could get married and to make knowing transmission of HIV/AIDS a criminal offence. During an interview with the authors of the report, it became clear that they were unaware of NASTL's liberal logic, and were surprised that programme staff had never got back to them about trying to develop their ideas.

Another example of how non-communication between the NAPCP and non-health groups is provided by its relationship with the traditional leadership. As discussed in chapter four, traditional leaders retain a significant degree of authority over communities, particularly in the rural areas that are difficult, if not impossible for government to access effectively. Just as importantly, however, they have influence on behaviours and values. In the first place, they are the custodians of social norms, customs and values. The issue of HIV/AIDS touches upon deeply-felt social values and beliefs, and traditional leaders have a considerable influence in the way people approach particular problems. Despite this, no consistent effort has been made to involve them in discussions about HIV/AIDS. A senior lawyer with a special interest in HIV/AIDS complained that traditional courts were routinely acting in discriminatory ways as well as condoning activities, such as sexual cleansing, which greatly increased peoples' risk of infection. In an interview in 1997, a district headman in Mazabuka province told me in an interview that he had only recently properly understood how AIDS was transmitted and that he had never been invited to any form of workshop on the subject. Once he had learned about the disease, he immediately banned sexual cleansing within his jurisdiction. Though traditional leaders have not been targeted for any education campaigns, traditional *healers* began being invited to AIDS training sessions from 1994. These conferences are effectively training sessions, teaching healers how to minimise their potential for transmitting HIV/AIDS. Healers are taught basic hygiene, how to improvise surgical gloves with plastic bags and what health practices they ought to avoid.[44] They are not organised in such a way as to encourage dialogue between the formal and informal health sectors about how to promote behaviour changes.

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44 Interview with Rodwell Vongo, Chairman of the Traditional Healers Association.

C. The key determinants of the WHO/GPA Strategy's impact

One of the most significant determinants of the WHO/GPA's impact was its technical expertise. In a country that had relatively few resources for research and policy development, the WHO/GPA provided state-of the-art information about HIV/AIDS and expertise and equipment for surveillance, testing and ensuring a safe blood supply for transfusions. They also provided an organisational base for launching interventions. The WHO/GPA were able to exploit their relative expertise in the area, its perceived neutrality and the fact that they had established an operational base in Zambia to act as a mediator and funding conduit between donor agencies and government. At the quarterly meetings donor meetings, participants would try to reach some form of consensus about funding priorities and how to allocate resources. The meetings' aim was to identify areas of priority need and for agencies to agree a complementary programme of support that was appropriate to each agency's specialism and programmes.

Like Britain, one of the factors that limited the extent to which the Strategy's aims were achieved was the tension between its liberal public health ideals and a more populist conservative morality. Senior politicians were reluctant to alienate their political supporters by seeming 'soft' on traditional Christian values. In Britain, however, the institutionalised position of the health policy community ensured that a relatively liberal approach to HIV/AIDS. 'Retreats into conservatism' occurred in relatively peripheral areas such as prisons. In Zambia, the organisational structure of AIDS interventions and the policy environment with which they were being implemented created a relatively bureaucratic and ineffective programme.

The effect of the WHO/GPA intervention in Zambia's policy environment led to HIV/AIDS policies being developed by what I will term a 'donor-dependent network', a heavily interdependent network of weakly-accountable state bureaucrats, donor agencies, members of government and large, service-providing NGOs. The relationship between these groups falls within the definition of policy network: a cluster or complex of organisations connected to each other by

resource dependencies and distinguished from other clusters or complexes by breaks in the structure of resource dependencies (Benson, 1982).

The first feature of this network was that all members were weakly accountable to the Zambian population. Bilateral agencies are ultimately accountable to their electorates at home and have relatively weak and/or opaque systems of accountability to their developing country constituencies (Guijt, 1998). As an extra-budgetary programme, the WHO/GPA programme depended on bilateral donations. Its long-term success, or otherwise, depended on the extent to which it could convince donors of its effectiveness. The WHO/GPA were not, therefore, directly answerable to the Zambian taxpayer, who bore only the opportunity cost of ineffective donor spending. The Zambian and expatriate health bureaucrats who were charged with administering and implementing the programme, also had relatively little formal accountability to the electorate. The most directly accountable member of the network were the executive who could, in theory, be voted out of office should policies fail to perform.

The second feature of this network was that all the members were heavily interdependent. Boundaries between the various 'national' and 'international', 'government' and 'non-government' groups were unclear. The NAPCP was designed and funded by the WHO/GPA. Its senior staff were all expatriates and it was housed in WHO offices. The government provided the support staff for the programme, but was not directly responsible for its operations. Similarly, formal NGO responses were heavily supported by the international community and were in many cases started by expatriates. At the same time, however, they worked closely with the government. These were not 'outsider' pressure groups. Instead, all the formal AIDS NGOs relied on government to provide staff. Their role was one of quasi-state service provision.

As an extra-budgetary programme of the WHO, the GPA was dependent on donors for funding. They had no long-term, reliable source of income and were reliant on being able to continue to persuade donors that they were an appropriate and useful channel for AIDS funding. They were also dependent on the Zambian

government, which provided the staff for the NAPCP programme and dominated the bureaucratic and political environment within which the programme had to work. Equally, all of the organisations involved in the NAPCP were heavily dependent on donors. This was not a case of reorganising existing state services or stimulating local responses to HIV/AIDS. With a health budget of around six dollars US per person per year, the Ministry of Health had no resources to fund vertical AIDS programme as it was conceived by the WHO/GPA. The relatively expensive technical services provided by the NAPCP would have to rely on external funding.

The process of allocating donor funding is however, a complex and political process. Variations in expenditures are an inevitable hazard in programmes that are dependent on external donor funding. A broad range of bilateral and multi-lateral agencies were involved jointly and separately in negotiations on AIDS spending, each one having their own priorities and agendas and each one ultimately accountable to their funding sources in the North. There is no clear hierarchy between these agencies. Any co-ordination of donor interventions is done in a voluntary and ultimately *ad hoc* basis. A wide range of factors influence decisions about the way in which scarce donor resources are allocated. Over time, individual agency's country strategies and priorities are likely to change. Relations between government and donor agencies vary. Sometimes, factors external to individual programmes affect donor priorities. To this extent, unpredictability of donor funding is a predictable phenomenon. Zambia's NAPCP, however, was designed in such a way as made it almost entirely dependent on donor funding.

The final feature of this network was that there was a clear break in the structure of resource dependencies between members and non-members. AIDS interventions in Zambia were clearly divided between those that came within the NAPCP umbrella and those that did not. Non-members had few formal opportunities to participate in policy-making and policy meetings were focused around the issue of co-ordinating member strategies. Those non-government organisations that received donor funding and were included in the network played by the 'rules of the game'.

They were sympathetic to the liberal public health approach upon which the programme was predicated and did not act as outsider pressure groups. Those groups that did not share these common principles were, such as traditional leaders and healers, were effectively excluded from the central core of policy-making.

AIDS policy, then, was developed by a relatively large group of interdependent organisations each of which had a limited ability to affect policy development. The measures that each group took to limit other group's influence had the effect of making policies that were bureaucratic and ineffective. President Chiluba's government did not sign the Global AIDS Strategy and does not appear to share its implicit values. As a state representative, his government may be held to have some form of moral duty to uphold the terms of international resolutions, but can not be compelled to. In common with all the UN agencies, the WHO operates on the principle of state sovereignty and the use of 'moral suasion' to influence state policies. The 'donor-dependent' network operated in such a way that there was little incentive for the new government to stop the programme, or to admit officially to reservations about it. The government was not funding the programme and its only contribution was to reallocate civil servants to the donor-sponsored programme. To refuse foreign-funded AIDS interventions would have prevented much-needed foreign currency from entering the country. Just as importantly, to have done so would have antagonised the donor community more generally, jeopardising future negotiations for debt relief and loans. The government would have been publicly out of step with the international consensus on an issue that is regarded as significant. What the government could do, however, was to limit the programme's more controversial interventions by ensuring that 'street level' bureaucrats did not 'over-publicise' the issue.

Donors then found themselves funding interventions that were being quietly undermined by the government in power. Having paid for the establishment of an AIDS programme and an information unit, the programme was becoming non-operational. Ultimately, however, donors have limited control over the policy environment in which their money is spent. Despite the international community's financial and technical resources, Chiluba's actions demonstrate that senior

members of the executive have leeway to adapt or undermine unwelcome interventions. In these circumstances, donors' only real sanction is some form of 'exit' from the policy arena. The most dramatic form of exit is to stop funding to a country completely or, more commonly, to stop funding particular projects and programmes. After the initial rush of funding, donor contributions to the Global AIDS Strategy internationally steadily declined, a reflection of donor doubts about the effectiveness of multilateral interventions on a long-term basis. Such an exit strategy was also adopted in Zambia. Norad, for example, has stopped contributing to the NAPCP while it waits to see how effective the health reforms are and whether the organisation survives the reshuffles.[45] A less drastic form of exit was to by-pass the government and instead fund NGOs. Since 1992, for example, USAID has been funding an NGO called Society for Family Health (PSI) to do 'social marketing': marketing subsidised condoms. The NGO is officially a 'private sector partner' to the government of Zambia but in practice, its relationship with government is strained. An attempt at formal collaboration with the government to produce a series of adverts promoting the acceptability of condoms was cancelled when the then Health Minister Katale Kalumba ruled that they were likely to promote a backlash from church groups and parliamentarians.[46] No formal collaboration has been attempted since. Short of 'exiting' the policy arena, donors also chose to retain control over the way their resources were used by ensuring that they were spent on 'tangible' interventions: capital costs, expert (expatriate) salaries, conferences and infrastructure (Atkinson, 1999). Rather than spending money on the day-to-day running costs of services, they chose to fund interventions where they can 'see where the money's going'. The result, however, was to further undermine the effectiveness of AIDS interventions, creating an under-funded organisational infrastructure.

The WHO/GPA were over-stretched and trying to stimulate official responses to HIV/AIDS programmes around the world. AIDS presented an extraordinary threat to world health and time was of the essence if its spread was to be

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[45] Interview with Health and Population officer, Norad.

[46] Interview with PSI representative, Lusaka.

contained. The speed with which national AIDS programmes were set up around the world meant that to some extent staff workers were compelled to adopt a 'cookie cutter' approach to the programmes, setting up standardised organisations and procedures across a broad range of low-income countries.[47] Establishing and funding a central bureaucratic space from which to monitor HIV/AIDS and to direct and co-ordinate interventions seemed like an essential and logical first step. In so doing, however, the WHO/GPA funded a programme that failed two of the basic preconditions for effective policy implementation (Hogwood and Gunn, 1984: 199). Firstly, staff at the National AIDS Programme lacked the political authority to develop and implement the AIDS policies for which it was nominally responsible. The WHO/GPA did not have the mandate to develop government AIDS policies, their role was simply to manage and co-ordinate donor-funded health services. Secondly, the WHO/GPA's AIDS interventions required political and financial resources that could not be relied upon when the policy was launched.

[47] Interview with a former staff member of the GPA.

Chapter seven:

Summary and conclusion: The Global AIDS Strategy and international policy co-ordination

Introduction

This chapter summarises the key points of the thesis, before discussing its implications for understanding international co-ordination and international policy interventions. The chapter is divided into two sections. The first section summarises the arguments I have put forward and the main findings of the research. In the conclusion, I will discuss the contribution this research makes to understandings international co-ordination.

1. Summary: The Global AIDS Strategy and the development of national policies

The Global AIDS Strategy provides a valuable opportunity to examine international co-ordination in a post-Cold War world. Endorsed in its full and final form the year the Berlin wall came down, it embodied a fusion of late 20th Century liberal ideals: Bretton Woods principles — in that it envisaged a UN organisation leading an international response to a world-wide problem — and a more recent re-emphasis on liberal pluralism and the significance of non-government groups in a democratic, effective polity.

The Strategy was, however, just a resolution and though expressed in bold terms, it had no legal force. In chapter one, I posed three questions: to what extent were the objectives of the Global AIDS Strategy achieved? In what ways did the WHO/GPA's Global AIDS Strategy impact upon national AIDS policies and what were the main factors that influenced these answers? I then reviewed the main, macro-level approaches to understanding international relations, arguing that they provide a poor framework for understanding. The issue raises questions about the relative influence

of different groups in the *actual* development of policies (as opposed to the declaration of intent); about the different *forms* of influence in international policy co-ordination and, the extent to which low-income affects compliance with international agreements. Policy analysis provides a more promising framework for empirical investigation of trans-national influences on policies, but approaches such as Lee and Walt's (1995) study of international Family Planning interventions are weakened by their failure to examine policy development subsequent to apparently consensual international conferences. Without proper consideration of each phase of policy evolution, it remains impossible to establish whether international agreements have any real impact upon policy development or, if they do, how that effect was achieved.

In chapter two, I put forward a framework for understanding the influence of a trans-national policy strategy. Given the ambiguity surrounding the issue of international policy co-ordination, there is a need for detailed, empirical observation of the political dynamics involved in generating an international consensus on policy issues and implementing agreed policies. In this thesis, policy analysis is used as a micro-level, descriptive theory to trace the development of HIV/AIDS policies, to account for the different groups involved in policy evolution and to explain how they sought to influence policy outcomes. Policy analysis approaches assume that various actors can influence policy developments, but that their abilities will be influenced by political and economic circumstances. 'Top-down' policy analysis has the advantage of a formal clarity that facilitates the careful analysis of policy evolution — this study is underpinned by top-down insights into the process of making and implementing policy. Such approaches can, however, be prescriptive and state-centric, assuming that (state) actors have sufficient autonomy to formulate and implement policies and that — with proper management — these policies will be a force for social good. They are correspondingly weak at explaining situations, like the Global AIDS Strategy, in which responsibility for formulating and implementing policy on a contentious issue falls between a number of different organisations with no clear hierarchy between them.

The foremost account of international policy responses to HIV/AIDS tries to offset these perceived weaknesses by adopting an ahistorical 'garbage can' approach to analysing the policy process. International AIDS policy, the authors argue, developed relatively randomly as different international organisations competed to claim expertise in the emerging issue. The analysis, however, tends to underplay the extent to which historical factors influence the choices available to groups and their relative ability to negotiate outcomes. Neither does it adequately explore national-level negotiations, focusing instead on general trends in donor policies and organisational adaptation within international organisations. Society-centred approaches give a more comprehensive picture of negotiations at various stages of policy evolution and provide a methodological approach that ensures that the unintended, as well as intended consequences of policy are captured and analysed. The research design of this study incorporates some bottom-up research methods in its broad range of interviewees. Here again, however, the approach's weakness lies in accounting for underlying *structural* inequalities between groups, which will impact upon the way policies develop.

Policy network theory provides analysts with a body of theory that avoids both the historical specificity and unpredictability of purely pluralist or society-centred approaches, and the determinism of either structural or state-centred approaches. In policy network theory, it is accepted that more than one group may influence policy outcomes, but that not all groups have equal ability to affect change. Some groups or sub-groups are able to act collectively, effectively to exclude other groups from the policy process. This ability varies over time and is affected by economic, organisational and ideological context — the policy arena or 'environment'. These relationships will in turn affect policy outcomes. Thus, in this thesis it has been used as a meso-level, explanatory theory.

Various writers have acknowledged the potential significance of policy networks in the international policy arena, particularly in regard to low-income countries (Dolowitz

and Marsh, 1998). Despite this, the theory has not been used for a detailed examination of networks in an international context. I therefore developed a framework for analysing the various groups involved in the implementation of the Global AIDS Strategy, from international organisations to grass-roots community groups.

In chapter three, I discussed the methodological implications of this research. One of the aims of this study is to look at how differences in income affected the relationship between national organisations and the international community. It is clear from the discussion of the previous chapters that these relationships are likely to be highly contextual. The Global AIDS Strategy was endorsed by every member of the UN and the huge differences in political and economic conditions of the signatories, combined with various weaknesses in the data available, would make a population-based survey unsound. I therefore adopted a case study approach, using Britain and Zambia as broadly illustrative of two 'types' of relationship with the WHO — that of donor and donee. The research was designed to explore the way the relationships evolved and how the WHO's Global AIDS Strategy affected the development of AIDS policies.

In chapter four, I went on to explore the policy 'environments' in the case countries. I argued that the way in which Britain's National Health Service was established had created an environment in which policy was decided by a relatively closed community of government bureaucrats and health professionals. Historically, British doctors have had relatively privileged access to decision-making bodies and significant influence over the way health policies have been developed (Smith, 1993). I also discussed the way in which this community was under deliberate attack from the Prime Minister at the time AIDS policy was being formulated. At the same period, Zambia was acutely impoverished and undergoing difficulties in its relationship with the international community upon which it was dependent for further loans, development assistance and debt relief. For historical and cultural reasons, political and economic power in the country was focused at the centre, in a weakly-accountable state apparatus. This

acute shortage of resources and heavy dependence on donor funding and debt relief created an environment in which HIV/AIDS policies were developed and operationalised by a group of heavily inter-dependent, weakly-accountable national and international agencies.

In chapters five and six, I discussed the findings of the research. The Global AIDS Strategy's influence had three, separate yet inter-related facets. In its most obvious sense, the Strategy was an internationally endorsed resolution, an international symbol of intention. The existence of this resolution had some, limited influence on policy development. Pressure groups reported using the fact that governments had signed the resolution to reinforce their arguments for liberal policies. Other things being equal, politicians are reluctant to appear isolated from the international community. UK Health Minister Virginia Bottomley's change of heart over mandatory HIV testing, for example, took place after civil servants had warned her how embarrassing it could appear if Britain was to introduce them so soon after the London World Summit of Ministers of Health.

The resolution did not just occur in a vacuum, however. It only came about after an international exchange of ideas, information and knowledge of HIV/AIDS. This exchange took place through journal articles, international conferences and professional contacts. Much of it happened quite independently of any formal attempt to organise the problem internationally. The second element of the Global AIDS Strategy's influence was to provide a way of organising this knowledge and reproducing it in useful, persuasive forms. The WHO became a mediator between governments on one hand and the AIDS issue network – scientists, health professionals and NGOs – on the other. They pooled information about HIV/AIDS and disseminated it in a way that would have relevance for governments. They processed information into relatively clear guidelines for governments to follow, making firm statements about international 'best practice'. They organised and funded international conferences, bringing politicians into contact with experts in the field.

Their staff 'sold' the problem to politicians and health bureaucrats in different countries. In so doing, they gave a new and complex problem a safe and familiar framework. Though serious, the HIV/AIDS problem was not unmanageable and by adopting clear trusted public health procedures, governments could control the situation. Just as importantly, governments *could be seen to be doing so*, both nationally and internationally. Much of WHO's influence on policy came from its ability to develop an international consensus on the way to approach AIDS, an ability which was in turn dependent on the perception that it provided neutral, policy-relevant information. Effectively, what the WHO was doing was to make information about HIV/AIDS *of* the political realm without *being* political.

This form of influence was particularly relevant in Britain. At the time AIDS was first identified in the UK, the NHS was under assault from government, perceived as being wasteful, expensive and unduly influenced by self-interested professional groups (Smith, 1993). At the same time, news of the 'gay epidemic' sparked fears amongst politicians, the public and health professionals alike and there was considerable pressure to adopt a stigmatising approach to those groups who were considered to be particularly at risk from AIDS or who were already HIV+. Despite this, health policy makers were able to develop an approach to HIV/AIDS that has been called a "triumph for a particular form of liberal consensus around AIDS, for traditional modes of health policy making which had long been heavily reliant on the power of the medical profession, but which Thatcherite reforms presumed to have overturned, for an elite rather than a populist view of what policy should be" (Berridge, 1996: 55). The WHO/GPA played a key role in helping to achieve this policy development by offering evidence about the scale of the problem nationally and internationally. It generated projections about the possible economic implications should state actors fail to act decisively to control the epidemic. Its staff collaborated with national AIDS activists to put pressure on governments. In so doing, it was able to support the health policy community in its endeavours to develop HIV/AIDS policies within a liberal public health framework.

As Claude (1966) argued, UN bodies can be an important source of legitimate authority because governments *perceive* them as being important. In a sense, then, UN agencies in general and the WHO/GPA in particular have no genuinely independent funds, coercive authority, or formal jurisdiction in the countries within which they work. Their influence comes largely from their ability to generate confidence in their work and the support of their 'co-operating partners'. That confidence is, however, never static and unchanging. It changes over time and with changes in personnel. In Britain, the ODA's confidence in the organisation declined as it tried to broaden its ambit beyond that of public health. In Zambia, the new MMD government clearly had a different relationship with the WHO/GPA than Kaunda had done.

The final facet of the Global AIDS Strategy's influence was that, having generated interest in the HIV/AIDS problem, it could provide an organisational mechanism for the administration of overseas development assistance. It became a conduit for donor funding and the redistribution of financial, technical and human resources from North to South. UN resolution WHA40.26 authorised the establishment of the GPA, which then became an important funding body of AIDS interventions in developing countries. With incomparable expertise in the field and an established international infrastructure, the WHO/GPA became the main channel through which donors funded AIDS interventions. This funding element of the Strategy influenced Zambian AIDS policy most directly. The WHO/GPA funded a national AIDS programme, situated within its offices, paid for interventions and hosted policy co-ordination meetings between donors, government and UN agencies. However, Zambia's externally-funded National AIDS Programme has had limited success at changing the behaviours associated with infection from the HIV virus. The programme created a centralised and bureaucratic administration that did not have the capacity to launch a full-scale governmental response yet, with few exceptions, has not been successful in galvanising support from the non-governmental sector. The services that are available to people with

HIV/AIDS are patchy and localised and have been persistently undermined by resource shortages.

2. Conclusion

A. Implications for understanding international policy co-ordination

This research has implications for our understanding of international policy co-ordination. Realist approaches contend that the state acts according to its long-term interests. The approach rests upon two assumptions, that 'the state' can act as a unitary, purposeful actor and that it has clearly-defined, hierarchically ordered interests. Logically then, international resolutions are only meaningful in as much as they coincide with the state's existing policy preferences. This research supports arguments that 'the state' is not a unitary actor, but a deeply divided ensemble of state agencies, each of which has different priorities, values and operational procedures. Furthermore, non-state groups can have a critical impact on the way in which state actors construct their interests. At the time the Global AIDS Strategy was signed it was not necessarily obvious that HIV/AIDS was a serious international problem, or that it should be tackled in according to the WHO's liberal public health values. In both Britain and Zambia, key state actors were actively hostile to liberal AIDS interventions. One of the more significant impacts of the WHO/GPA on policy development was to assemble evidence that managed to persuade state policy-makers that HIV/AIDS *was* a serious problem and that it was in the state's interests to address it before the problem became worse. By generating epidemiological evidence about its impact, and calculating the disease's potential economic impact, they shifted state actor's perceptions about the 'national interest'.

In addition to this form of technical persuasion, the WHO/GPA had another form of influence over the way state actors perceived their 'interests'. By using evidence to build an international consensus on HIV/AIDS and organising high-profile international fora, the WHO were able to generate a situation where diplomatic pressure could be put on state actors. State actors do not necessarily have a clearly

ordered pre-existing set of interests. They have to balance short-term interests against longer-term ones, play off political gains with one group against losses with others. When, for example, UK Health Minister Virginia Bottomley voiced a preference for mandatory testing, DoH and WHO/GPA staff were able to use the London Summit of Ministers of Health as a lever to convince her that her idea would draw adverse policy to herself, her department and her country. Her short-term strategy for monitoring HIV transmission suddenly became less important than maintaining her department's international standing. However, the fact that such a stance would be considered outside the 'international' norm, was largely a product of the WHO/GPA's efforts at constructing a plausible conceptual approach to the issue and publicising the issue internationally.

The functionalist approach to understanding international relations assumes that policy co-ordination is an inevitable by-product of modernity. Increasing economic interdependency inevitably leads to policy convergence and international co-ordination is efficient in that it minimises the costs of policy development and reflects the way that organisations react to policy issues in an innately conservative way. Such approaches undoubtedly offer insight into the pressures driving increasing international policy co-ordination. HIV/AIDS provided policy-makers with a new and unexpected problem and the fact that WHO was pooling information about it, bringing experts together and publishing policy guidelines influenced the way different policy options were viewed. 'The WHO' approach to AIDS came with a package of solutions and a stamp of multi-lateral approval. Pursuing alternative approaches would necessarily be experimental, might involve policy-makers in greater development costs and could potentially isolate them from the international community.

Knowledge about HIV/AIDS was developed and disseminated by a genuinely international community of scientists, medics, pressure groups and health bureaucrats. This group falls within the definition of an 'epistemic' community, a "network of professionals with recognised expertise and competence in a particular domain and an

authoritative claim to policy-relevant knowledge within that domain or issue-area" (Haas, 1992: 3). The fact that AIDS was a new and poorly understood problem gave these, non-government actors room to influence policy development by virtue of their ability to put forward a plausible framework for understanding complex problems, helping states to identify their interests and proposing particular solutions (Haas, 1992). Though some of the more high-profile AIDS activists came from pressure groups and NGOs, the most influential group within this community were undoubtedly medical by background. Liberal medics provided a respectable and overarching conceptual framework within which to organise *ad hoc* NGO responses to AIDS. Medical professionals comprised the most organised, politically acceptable and influential groups and had genuinely international communication mechanisms in place.

However, the research also indicates that the epistemic community's influence *per se*, was relatively limited. In Britain, liberal, public health approaches to AIDS prevention and control were only incorporated into policy in areas where liberal, public health bureaucrats had institutionalised access to the policy process. In other areas, such as Home Office policy on needle-exchanges in prison or the Ministry of Education's policies on sex education, Britain has pursued policies that run against the general trend of public health policy. Similarly, Zambian members of government have had a considerable influence over the direction of HIV/AIDS policies, despite the strong and committed interventions from the international community.

The AIDS 'epistemic community' were most influential when members were either an integral part of the policy process at the national level — such as the health policy community in Britain — or were already accepted as legitimate sources of authority and had organisational structures in place with which to lobby governments — such as the WHO. Moreover, their most dramatic influence was exerted over a relatively short period of time: a time of confusion and mounting panic about the disease. Bureaucrats were able to seize initiative in the short term by virtue of putting forward a sustained, persuasive argument to explain why certain policy options. In so doing,

they managed to generate significant funding for AIDS interventions at home and abroad — at a time of state retrenchments in health and overseas development assistance. This influence was, however, relatively short term. In the longer-term, donor agencies began to revert to their more usual bilateral agreements with donor agencies and funding for AIDS interventions generally began to decline.

This history of the development of HIV/AIDS policy in Britain and Zambia reveals various examples of individuals or groups acting as autonomous agents to influence the direction of policy. In the early stages, the 'AIDS Missionaries' publicised and 'sold' the problem to policy-makers. Government bureaucrats worked with WHO/GPA staff to put pressure on governments. President Chiluba quietly redirected policy away from the high-profile mass-media campaigns that were being advocated by the WHO. These acts of agency power were, however, relatively random and *ad hoc*, dependent on the initiative and skills of individuals. In the longer term, the relative influence of different groups in policy development was largely path dependent, a function of the extent to which group preferences were institutionalised within existing political and ideological frameworks.

Chapter two provided a discussion of 'agency' and 'structural' power, arguing that structural power resided in four separate, distinguishable but related structures: security; production; finance and knowledge. In this area of 'low-politics', the structures of finance and knowledge proved particularly important determinants of relative group influence. Much of the WHO/GPA's influence derived from the fact that it provided government agencies with knowledge and information that was regarded as authoritative. Its medico-liberal values 'fitted' within the dominant liberal ideology upon which the Bretton Woods system is based. It also had the organisational means to reproduce and disseminate its approach to HIV/AIDS effectively: an international administrative infrastructure and recognised authority in the area. This knowledge structure, however, was underpinned by its ability to generate income from the international community. Conversely the Zambian state's

dependence on donor community compromised its autonomy to directly reject the WHO's policy initiatives.

It is also apparent that shared ideas and values at the international level generate very different sets of policy solutions once transposed into different policy environments. The resource asymmetries in the contemporary global political economy make for a two-tier set of relations with international organisations. The Global AIDS Strategy was nominally just that, a 'global' strategy. In practice, neither the WHO nor organisations in industrialised countries regarded WHO's assistance as necessary in developing HIV/AIDS policies in high-income states, except for very specific, technical advice. The 'global' strategy evolved into a mechanism for generating support, funding and expertise to launch a largely pre-determined set of initiatives in low-income countries.

B. The contribution of the research.

The contribution of this research is twofold. On an empirical level, it has gathered data on a complex set of relationships between the WHO and Britain and Zambia. It has then extended policy network theory to a discussion of the developing country policy environment and to international policy communities, both of which have been identified as a research priority. The research indicates that network theory can be a useful way of understanding and explaining policy outcomes in international policy interventions. In the first chapter, I discussed Lee and Walt's (1995) study of the effect of decades of international agency pressure to promote family planning programmes in low-income countries. The authors assert that receptivity to these pressures was a function of a) improving relations with the Western community and b) economic crisis, which had given governments less room to resist international pressure. I argued that these two determinants were paradoxical. Either governments were 'forced' to adopt policies, or they chose to because they believed them to be convincing.

By disaggregating the notion of a unitary 'state', policy network theory can explain this apparent contradiction. In Zambia, different state agencies adopted the terms of the Global AIDS Strategy for different reasons. Staff at the Ministry of Health were undoubtedly extremely concerned about HIV/AIDS and supportive of the WHO/GPA initiative. Regular international conferences and contact with WHO staff reinforced a liberal public health consensus about the disease. In contrast, a senior-subset of government led by the President strongly disapproved of the whole basis of the WHO/GPA's initiative. Despite showing no apparent interest in stopping an inflow of funds from abroad, they were able to use political interventions to curtail its effective policy implementation.

It is however, on a second level that the research makes a more useful contribution. By comparing the relationship between WHO and two countries of such radically different political and economic stature, it has allowed for examination of two very different yet inter-related processes. The case study of Britain describes the process by which knowledge is constructed and disseminated by international collaboration between experts. The case study in Zambia looks at the way this knowledge is used and applied in developing countries. These two processes are inseparable, different sides of the same coin. Yet the academic tradition of treating them as separate — one the domain of international relations, one of development studies — means that many of the assumptions that underpin aid interventions are never fully explored.

During the course of this research some of the interviewees expressed surprise, even indignation at the apparent naivety of the comparison of the relationship between the WHO and Britain and Zambia. These respondents — without exception the consultants and staff of international aid agencies — expressed the view that 'of course' the WHO was not for industrialised countries, it was for developing ones. This is an interesting assumption. The UN system, including its specialised agencies like the WHO, was predicated on the principles of universality. Similarly, the Global AIDS Strategy was endorsed as just that, a *global* strategy. Yet clearly, there are very

real differences between the member states and these differences radically affect the way they are perceived and the nature of their relationship to the international community more generally. These interviewees, caught up in the frustrating and upsetting complexities of implementing policies in developing countries were offended by the comparison because it seemed to ignore or downplay the real problems there. *Of course* agencies like the WHO have to focus their efforts in low-income regions like Africa. After all, African states are desperately impoverished and have no funds to launch extraordinary interventions. Unlike the industrialised countries, they have limited expertise and poor information on which to base policy. In the circumstances, it is only right that international agencies focus their efforts on advocacy and technical support in developing countries.

Such assumptions underpin many of the day-to-day activities of international agencies. These types of assumption, however, explain the way the programme developed. The research shows that in Britain and Zambia's earliest responses to HIV/AIDS were relatively similar. In both countries, doctors and NGO workers collaborated with each other to put AIDS on to the government agenda. Both formed special committees to advise government on the issue and both launched a government-sponsored public education campaign in 1987. Yet after the initial period of consensus-building, WHO's relationship with the two countries diverged dramatically, a difference underpinned by the assumptions I have outlined. If developing countries lacked resources, then what was needed was a flow of funds from North to South. It lacked experts, and needed expatriate consultants. Its administration was inadequate to tackle the problem, so it needed a new office run by WHO administrators. Finally, its reluctant government needed to be taught that AIDS was a serious problem. Advocacy became an important part of the WHO/GPA's intervention, organising and funding a series of seminars for civil servants.

This research indicates, however, that WHO/GPA's interventions went on to under-perform for precisely the reasons it was launched in the first place. There were no

resources to fund the day-to-day costs of interventions as they were conceived by the WHO/GPA. The 'expertise' from international organisations was often inappropriate for the circumstances. An approach based on individual responsibility for the prevention of AIDS proved relatively ineffective in circumstances where many people either perceived 'risk' differently from those in the West, or lacked autonomy to choose the extent to which they exposed themselves to it. The WHO/GPA created an administrative structure with which to tackle AIDS, but found that it was never able to integrate its activities with existing state organisations. Instead, it became embroiled in a lengthy process of on-going reorganisation. Finally and most importantly, senior members of government were deeply hostile to liberal AIDS interventions and could not be seen to actively condone them for fear of alienating an important part of its constituency: fundamentalist Christians. The result was to create a bureaucratic response with a limited effect at controlling HIV/AIDS. In the process, the combined efforts of government and donors overlooked the resources that *were* available: religious and community groups, the existing government bureaucracy and the traditional leadership.

The strength of basing research on a comparison of the two countries is that it helps to expose some of the assumptions that underlie overseas development assistance. It explains how and why relationships differ and what effects these differences had on policy evolution. It is widely acknowledged that development interventions are frequently organised within a Western template (Caiden and Wildavsky, 1974). This research makes these comparisons explicit, laying bare the process of very different relationships. It brings the Third World onto the centre stage of the debate on trans-national policy making.

The case studies in this research were chosen for their intrinsic interest. They are not, and were never intended to be 'representative' in the statistical sense. Despite this, I would argue that it is still possible to use evidence from these case studies to make *theoretical* generalisations. In this thesis I have identified a particular form of 'donor-

dependent' policy network, consisting of a relatively large number of weakly accountable state agencies each of which has a limited but not decisive influence over policy outcomes. The effect of such networks on policy outcomes is to make interventions relatively bureaucratic and relatively top-down. I would argue that such networks operate in similar, low income, heavily indebted countries and that their presence may make a significant impact on the development of policies more generally. If this is the case then, rather than being a one-off 'learning' experience, the problems in operationalising the WHO/GPA's Global AIDS Strategy look to be part of a more underlying problem of the complex and compromised political environment in which policies are made in low-income, donor-dependent states. In the 1970s, Caiden and Wildavsky (1974) put forward a compelling argument for why donor-sponsored attempts at central planning in low-income countries were persistently failing. The authors argued that economic plans were specifically designed to raise government revenue, develop infrastructure and develop skills. Paradoxically, however, in order to be operationalised effectively, these plans would require appropriate resources, an established infrastructure and a skilled public sector. The result was to create a profusion of administrative structures, and industrial plant that failed to achieve their objectives of economic and political development because the conditions that would be required to make them effective were not in place.

Nearly fifteen years later, the design of the Global AIDS Strategy reflected similar weaknesses as those described by Caiden and Wildavsky. Though the Strategy used the language of 'co-ordination' and governance rather than that of now discredited economic planning, it was still an essentially Western programme. The Strategy was based upon an ideal-type of administrative structures and policies from the West which were then used as a template for interventions in the South. It also assumed conditions that were not in place. What was left after a decade of donor interventions, is the administrative apparatus without the services. Viewed in this light, forty years of development interventions since independence have left an archaeology of abandoned, inappropriate administrative structures and projects. The failing lies not in

the individual projects themselves, but in the policy environment in donor-dependent countries. Heavily indebted, resource-poor states are persistently failing to develop appropriate local responses to problems while donors continue to fund bureaucratic infrastructures. Until mechanisms are in place for ensuring policy-making is more sensitive to the needs and capabilities of individual countries, donor-funded interventions will continue to under-perform.

Appendix one: Interview Schedule

Request whether I can use a tape recorder and whether the interviewee would like to remain anonymous

Obtain brief details of the interviewee's current status and professional background.

Give brief explanation of the Global AIDS Strategy (showing diagram of its structure if necessary) and explain the main objectives of my research.

1. I would like to ask you about your experience of the WHO/GPA's Global AIDS Strategy

What, if anything, was its impact upon your organisation?

Was this association formalised (through joint-ventures, project approval etc) or more informal?

What, if anything, do you see as having been its overall contribution?

2. Have you, or your organisation, ever tried to influence WHO/GPA policies?

What happened?

3. To what extent do you feel that the WHO/GPA strategy was appropriate and effective in the circumstances?

4. To what extent do you think the objectives of the strategy were actually achieved?

Why do you think this was the case?

5. Are there any other individuals or organisations you think it would be useful for me to talk to?

Notes on questions

Question one was designed to be as non-directive as possible. I wanted to hear the respondents own account of the way the WHO/GPA impacted upon them without directing them as to whether any impact was formal, informal, financial or non-existent. After allowing them to elaborate on this, I gave them a more specific prompt about particular forms such an impact might take to try to ensure all possible forms of involvement were discussed. The final prompt was designed to invite more general discussion about the strategy as a whole. While it may not have affected a particular organisation, they may have views about its impact more generally.

Question two was designed to explore issues about consensus. Were organisations broadly in agreement with the overall strategy or were there pockets of domestic resistance? To what extent and by what means were any differences resolved? I wished to explore networks of communication and the process of policy negotiation.

In many ways question three had the least direct relevance to my specific research objectives. I originally intended it to be a safety net to questions two and four, where people could talk about the ways in which conflict was managed. In practice, it turned out to be one of the most productive questions. Those people who been slightly guarded, as though they should be giving the 'right' answer discussed this, more general question much more animatedly. Indirectly, the question produced detailed information about the way interest groups actually manage and negotiate practical difficulties and ideological differences.

Question four was designed to elicit information about the implementation process and the way in which different groups perceived the overall success with which the strategy's objectives had been achieved. Question five was designed to do a 'snowball sample' of relevant organisations. I wanted to expand the original list of interviewees to include those organisations who may have been influential in the

development of HIV/AIDS policies in a way that was not envisaged in the Global AIDS Strategy.

Appendix 2: Bibliography

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